US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Hudson Valley Healthcare System in Montrose, New York

Healthcare Facility Inspection	24-00601-254	September 24, 2024

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established a cyclical review program called Healthcare Facility Inspection. The Healthcare Facility Inspection team reviews Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG inspected the VA Hudson Valley Healthcare System during the week of February 12, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture across multiple dimensions, including system shocks (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. During interviews with the OIG, facility leaders identified the COVID-19 pandemic as a system shock. Despite experiencing challenges related to the pandemic, facility leaders made continuous process improvements, including expanding virtual capabilities and telehealth access and increasing transparent communication. Responses to an OIG-administered survey showed employees were divided about whether the culture of the facility was moving in the right direction. The OIG found that overall, employees who responded to the surveys felt empowered to suggest changes without fear of reprisal, and leaders strived to continually improve veterans' experiences.

Environment of Care

The OIG examined the general touchpoints of entry (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG physically inspected patient care areas, focusing on safety,

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

cleanliness, infection prevention, and privacy. The OIG also compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

During an area snowfall, the OIG found snow removal was adequate on roads and sidewalks, but snow blocked pathways to the buses. The OIG considered the needs of sensory-impaired veterans in approaching the main entryway and identified multiple accessibility options. However, the OIG observed an automatic door that was activated by a hand-wave motion sensor, which could cause difficulty for visually impaired veterans entering the main doors. While the OIG found the main entrance welcoming, it did observe a water leak from the roof because of a recent snowfall. Facility staff responded to the issue by placing a bucket to catch the water and a caution sign to alert visitors. Staff identified the leak as a systemic issue but reported a plan to replace multiple roofs. Volunteers staffed the main entrance to assist visitors with navigation and provide facility information. However, the OIG did not observe any toxic exposure screening materials at the main entrance and was concerned that veterans cannot easily access the information. The OIG assessed signage as clear and visible; however, it lacked information regarding services located in each building. The OIG made four recommendations.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight report findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined facility leaders had a process to communicate urgent, noncritical abnormal test results to ordering providers and patients. The facility had one open recommendation and a corresponding action plan from an internal VA review related to the communication of test results. Through interviews, the OIG learned that multiple committees monitored corrective action plan results, and leaders had several means to identify opportunities for improvement.

Primary Care

The OIG examined whether facilities' primary care teams were staffed per VHA guidelines and received support from facility leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[2] Two primary care team positions were available in the 12 months prior to the inspection, but the positions had since been filled. There were no primary care nursing vacancies because of recruitment incentives and special salary

[2] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

rates. Primary care team members described feeling supported by facility leaders and explained that staff had input and opportunities to improve efficiency and team function. The OIG found that veteran enrollment had decreased over the three years prior to the inspection, which leaders attributed to people moving out of the area due to the increased cost of living.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development-Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. The OIG found the facility staff effectively identified and enrolled veterans. The homeless programs staff identified barriers to meeting veterans' needs, such as obtaining veterans' vital documents for program enrollment and having limited affordable housing options available. Staff worked closely with community partners to address these challenges.

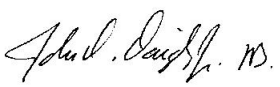
What the OIG Recommended

The OIG made four recommendations.

1. Facility leaders submit a plan to the OIG detailing steps to address snow removal on pathways leading to and from buses during and after snowstorms.
2. Facility leaders consider clarifying signage by identifying the services located in each building to help direct veterans.
3. Facility leaders implement navigation tools and cues that accommodate visually impaired veterans to help them enter the main doors.
4. Facility leaders consider distributing toxic exposure screening information where veterans can easily obtain it when entering the facility.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C, D, and E, pages 37–40 for the full text of the directors' comments). Based on the information provided, the OIG considers recommendations 1 and 4 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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

Abbreviations

CLC	Community Living Center
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Hudson Valley Healthcare System
Montrose, New York
Level 3-Low Complexity Facility
Westchester County
Hospital Referral Region: White Plains

Description of Community

RACE AND ETHNICITY

MEDIAN INCOME

$72,392

EDUCATION

89% Completed High School
64% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **233**

POPULATION

Homeless - State
74,178
Homeless Veteran -State
990

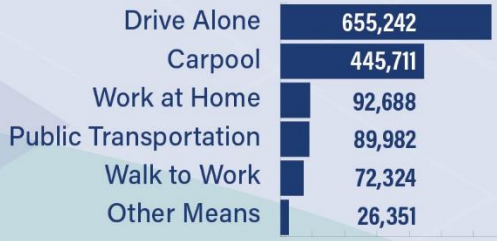
UNEMPLOYMENT RATE

5% Unemployed Rate 16+
6% Veterans Unemployed in Civilian Work Force

SUBSTANCE USE

20.1% Driving Deaths Involving Alcohol
20.2% Excessive Drinking
1,360 Drug Overdose Deaths

TRANSPORTATION



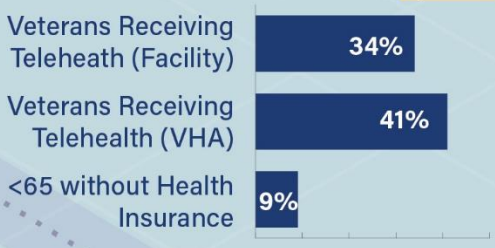
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**13 Minutes, 7.5 Miles**
Specialty Care	**27 Minutes, 20.5 Miles**
Tertiary Care	**62.5 Minutes, 55.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **7,340**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

6,003

36 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.44 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
10	19

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	23K
Unique Patients VA Care	22.5K
Unique Patients Non-VA Care	4.6K

COMMUNITY CARE COSTS

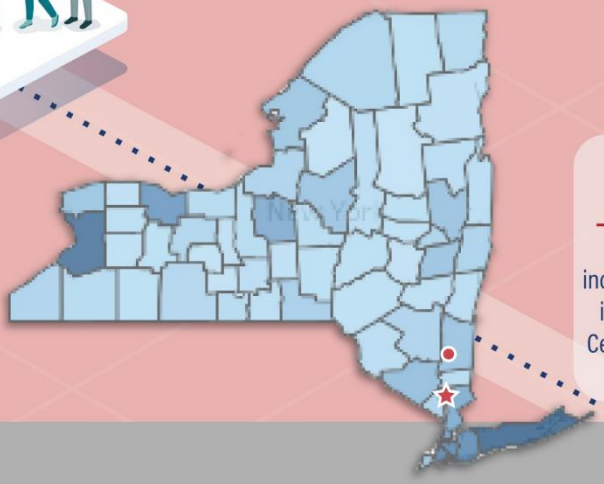
Unique Patient $9,556	Outpatient Visit $334
Line Item $114	Bed Day of Care $406

VETERAN POPULATION

466 — 56,446

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.09%
Facility Total Loss Rate	12.37%
Facility Retire Rate	3.66%
Facility Quit Rate	7.69%
Facility Termination Rate	0.81%



★ Franklin Delano Roosevelt Hospital

● Castle Point VA Medical Center

The VA Hudson Valley Healthcare System includes the Franklin Delano Roosevelt Hospital in Montrose, NY and Castle Point VA Medical Center in Wappingers Falls, NY. The OIG visited the Franklin Delano Roosevelt Hospital.

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established a cyclical review program, called Healthcare Facility Inspection (HFI), to help accomplish its mission. HFI teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework.*
Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

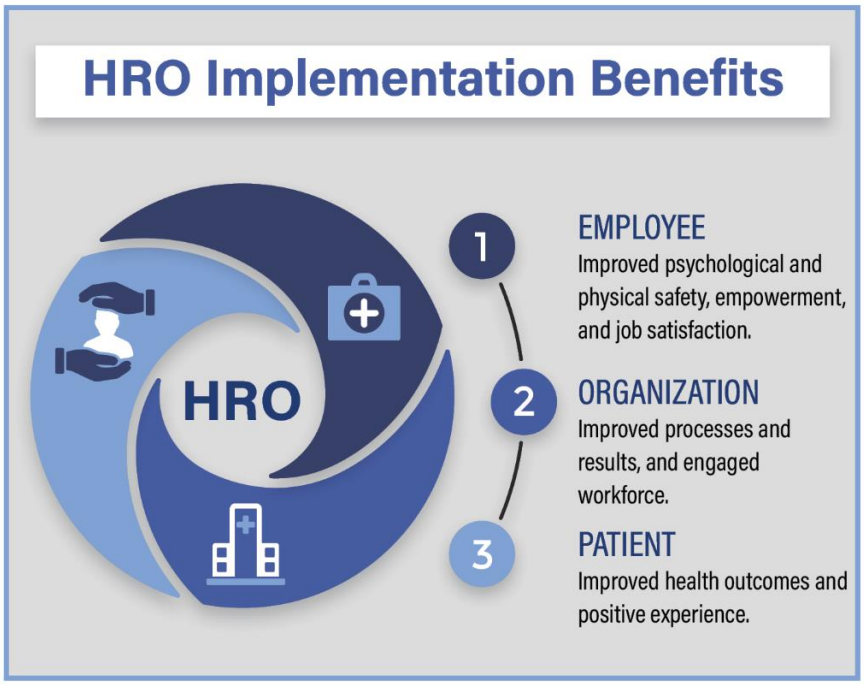


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised April 2023.

[6] "VHA's Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9]

The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[7] "PSNet, Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety* 18, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022); The White House, "FACT SHEET: President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans," press release, August 10, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/.

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA, accessed May 1, 2023, https://www.accesstocare.va.gov/pdf/VA_PACTActDashboard.pdf.

Figure 3. *HFI's five content domains.*
** Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review;" VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report, https://www.va.gov/HOMELESS/VA-Homeless-2022-HPO-Annual-Report-508c.pdf.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The VA Hudson Valley Healthcare System (facility) opened and began providing inpatient services on May 15, 1950. At the time of the inspection, the facility's executive leaders consisted of a Medical Center Director (Director), Chief of Staff, Associate Director of Patient Care, Associate Director, and Assistant Director. The newest member of the leadership team, the Assistant Director, was assigned in the beginning of 2022; the Director had been in place since May 2020; and the Chief of Staff and Associate Director of Patient Care had served in their roles since 2019 and 2015, respectively. In fiscal year (FY) 2023, the facility's medical care budget was approximately $336 million. The facility had 446 operating beds, including 15 hospital beds, 30 psychiatry beds, 297 community living center (CLC) beds, and 104 domiciliary beds.[13]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, under developed, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, workplace diversity, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VHA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/GERIATRICS/pages/VA_Community_Living_Centers.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp.

[14] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

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

[16] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18]

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. Facility leaders reported they continue to feel the impact the COVID-19 pandemic had on healthcare operations. Leaders shared that during the pandemic, staffing shortages occurred as some employees retired and others accepted positions offering more competitive salaries. In response to the shortages, leaders offered hiring incentives, such as special pay rates, to remain competitive with community employers, which had been effective in filling vacancies.

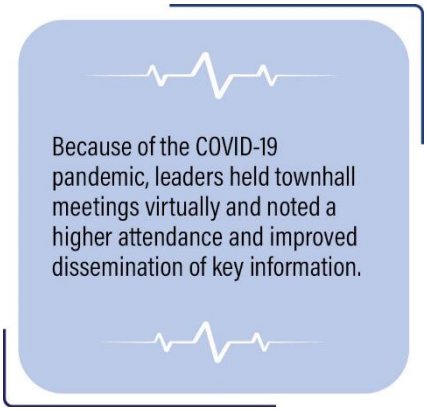


Figure 4. *Facility system shocks. Source: OIG interview.*

Facility leaders said that pandemic-related challenges helped them to better define practices. For example, leaders increased the use of virtual capabilities for more comprehensive communication among staff and expanded telehealth access for patients.

The OIG found the facility did experience a system shock and leaders were effective in managing challenges. The OIG made no recommendations.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[19] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright

[17] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[18] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies;" Department of Veterans Affairs, *VHA HRO Framework*.

[19] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

culture.[20] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[21] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[22]

The 2023 VA All Employee Survey and an OIG-administered questionnaire indicated staff perceived leaders' communication to be transparent.[23] Facility leaders described increasing efforts to communicate transparently with frontline staff; these efforts included monthly in-person and virtual town halls, weekly newsletters, regular visits to staff, and increased written communication. Leaders identified the largest barrier to communication with staff as the geographical distribution of their physical work locations. The OIG found facility leaders' efforts to facilitate direct and open staff communication were effective and made no recommendations.

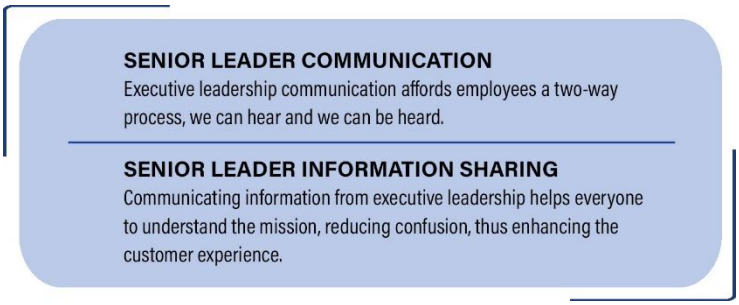


Figure 5. *Leader communication with staff.*
Source: Staff responses to the OIG-administered questionnaire.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[24] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[25] Organizations with cultures that celebrate diversity and inclusion encourage self-expression and enhance psychological safety, part of the safety culture, which is foundational to

[20] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[21] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[22] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

[23] The VA Hudson Valley Healthcare System had 1,427 employees, and the OIG received 356 responses to the questionnaire.

[24] The definition clarifies "unique" as "including but not limited to race, color, national origin, ethnicity, sex, sexual orientation, gender identity, religion, disability status, age and mutable characteristics such as educational background, socioeconomic status, organizational level, geographic region and cognitive/intellectual perspective." VA Directive 5975, *Diversity and Inclusion*, April 29, 2021.

[25] L.E. Gomez and Patrick Bernet, "Diversity Improves Performance and Outcomes," *Journal of the National Medical Association* 111, no. 4 (August 2019): 383–392, https://doi.org/10.1016/j.jnma.2019.01.006.

an HRO.[26] Having workplace staff representative of the veterans and surrounding community can build trust, facilitate communication, and strengthen the relationship between the facility and veterans served.[27] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.

Figure 6. *Facility workforce diversity.*
Source: OIG analysis of facility human resources data.

The OIG reviewed All Employee Survey responses for workforce diversity, which remained stable over the past three years. The Equal Employment Opportunity Manager reported collaborating with Human Resources and Special Emphasis Program Managers to enhance diversity in hiring practices, which included encouraging managers to assemble a diverse panel to interview applicants.

Leaders explained they were in a competitive market with other employers, which made it challenging to recruit applicants. In response, leaders promoted open positions through information sessions at local schools and teamed up with community organizations to target diversity in hiring for both entry-level and advanced positions. Additionally, leaders discussed a monthly radio spot in which the Director promoted employment opportunities to veterans. To improve workplace inclusiveness, leaders described encouraging employee participation at multiple diversity-focused events during the prior year through emails, meeting announcements, and town halls. The OIG found that facility leaders were committed to improving workplace diversity and inclusiveness through community outreach and diversity-focused events. The OIG made no recommendations.

[26] Psychological safety is the perceived ability to express one's thoughts and opinions without fear of negative repercussions. Barjinder Singh, Doan Winkel, and T.T. Selvarajan, "Managing Diversity at Work: Does Psychological Safety Hold the Key to Racial Differences in Employee Performance?" *Journal of Occupational and Organizational Psychology* 86, no. 2 (June 2013): 242–263, https://doi.org/10.1111/joop.12015. Department of Veterans Affairs, *VHA HRO Framework*.

[27] Marcella Alsan, Owen Garrick, and Grant Graziani, "Does Diversity Matter for Health? Experimental Evidence from Oakland," *American Economic Review* 109, no. 12 (2019): 4071–4111, https://doi.org/10.1257/aer.20181446. "An inclusive environment enables Veterans and employees to feel safe, respected, engaged, motivated, and valued for who they are and their contributions toward organizational goals." Office of Health Equity, Veterans Health Administration, "Increasing Diversity in Recruitment and Advancement Across VA to Achieve Equitable Care and Outcomes," June 2023, https://www.va.gov/IncreasingVAWorkforceDiversity_June2023_FINAL.pdf.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[28] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[29] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

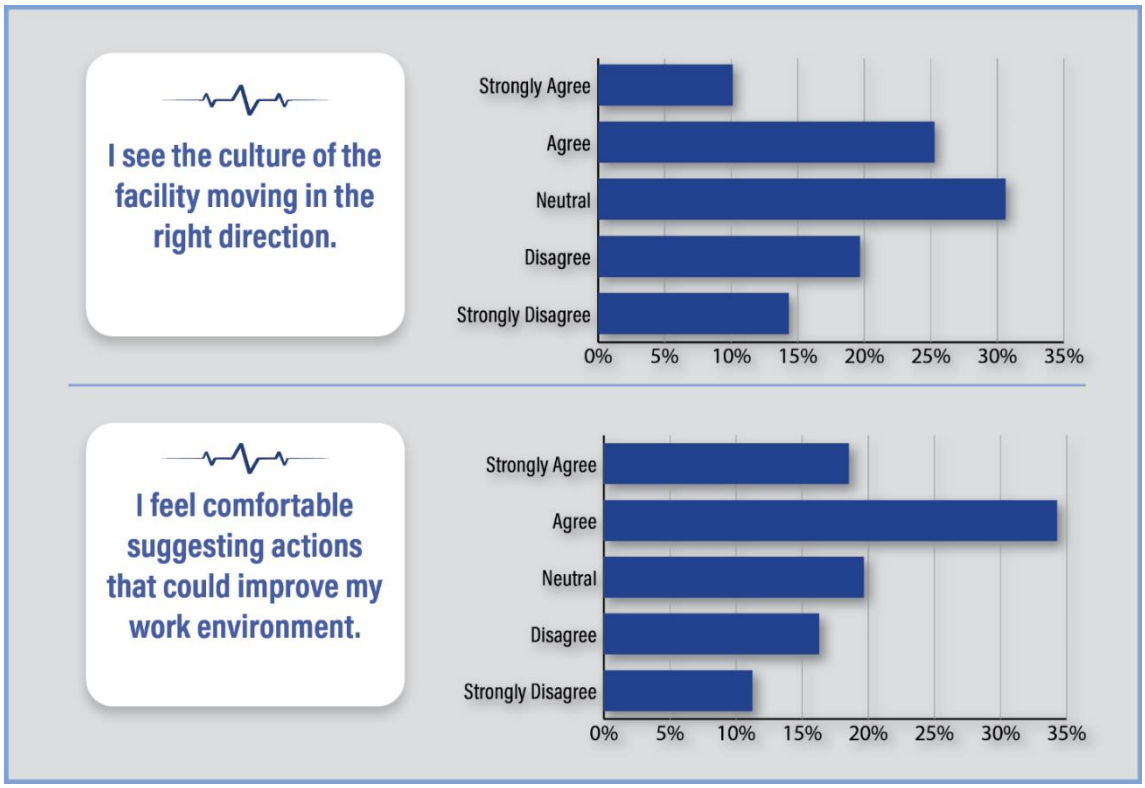


Figure 7. *Employee and leaders' perceptions of facility culture.*
Source: Analysis of OIG-administered questionnaire responses and interviews with facility leaders.

[28] Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[29] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

The OIG also reviewed VA's survey scores for measures affecting employee experiences. The scores for supervisor trust, no fear of reprisal, and best places to work increased from FYs 2021 to 2023.[30] Although scores for best places to work increased for the facility overall, scores for several departments had declined. Through interviews, the OIG learned that leaders coached supervisors on ways to improve employees' experiences, held focus groups to learn what was meaningful to the employees and attended meetings to hear from them directly, and visited the departments frequently to demonstrate their commitment to improvement.

Facility leaders discussed the importance of the survey and stated they collaborated with VHA's National Center for Organization Development to find ways to increase participation.[31] Leaders added the survey response rate increased from 66 percent to 85 percent because of the collaboration. Leaders also explained that efforts to build trust with employees, such as increased visibility around the facility, resulted in upward trends in survey scores.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The OIG found the VA survey scores increased from FYs 2021 to 2023. In responses to the OIG's survey, employees described feeling empowered to suggest changes without fear of reprisal. Facility leaders discussed holding employee engagement events, such as kickball games, to create an environment where employees feel comfortable speaking directly with leaders. Leaders added that engaged employees would translate to improved care for veterans. Furthermore, survey responses indicated a strong employee commitment to serving veterans.

The OIG found facility leaders were committed to improving the employee experience and survey scores reflected they felt psychologically safe to raise concerns to leaders. The OIG made no recommendations.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[32] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to

[30] Supervisor trust measures employees' trust and confidence in their supervisor; no fear of reprisal measures employees' perceived ability to disclose a suspected violation without fear of reprisal; and best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2020 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA Support Service Center.

[31] VHA's National Center for Organization Development's mission is to support leaders with creating a highly engaged workforce. "VHA National Center for Organization Development," Department of Veterans Affairs, accessed April 2, 2024, https://dvagov/VHANationalCenterforOrganizationDevelopment. (This website is not publicly accessible.)

[32] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

veterans and their families.[33] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Leaders provided the OIG with an internal report which demonstrated that veterans reported almost 100 percent satisfaction with their experience of care. Based on survey responses and interviews, the OIG found that veterans complained about clinic staff not answering phones and facility leaders were responsive to the concerns. Leaders said they addressed the unanswered calls by retraining staff, ensuring staff availability, and using both a local and Veterans Integrated Service Network call center to manage incoming calls.[34] Leaders added that when a veteran's concern was related to provider or nursing staff, they discussed the concern with the veteran and the staff member separately to resolve the issue.

Leaders acknowledged the importance of fostering trust with their local VSOs. These leaders shared that a VSO raised a concern to facility leaders about veterans quickly receiving services when they experience mental health crises, which prompted an improved admission process for hospitalizations at the facility.

The OIG found facility leaders collaborate with VSOs to understand and improve veterans' experiences. The OIG made no recommendations.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[35] The OIG examined the general entry touchpoints, which are features that assist veterans in accessing the facility and finding their way around. To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints, including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this

Figure 8. *Facility photo.*
Source: Photo taken by OIG inspector.

[33] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation), November 19, 2008, https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

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

[35] VHA Directive 1608(1).

inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[36] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, Architectural Barriers Act guidelines, and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[37]

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

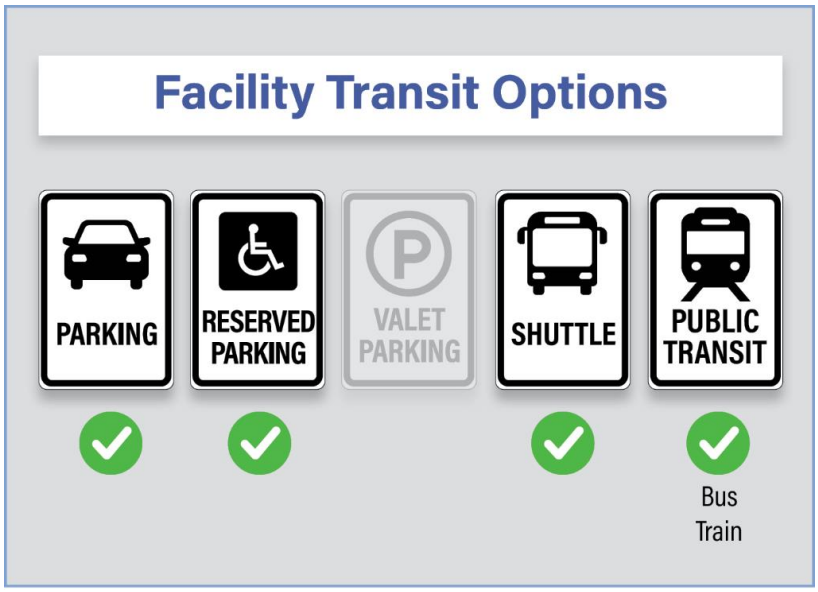


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents, interviews, and observations.

The OIG inspection team used a navigation link located on the facility website to obtain directions to the facility. The link navigated the team to a location near the facility, but the endpoint was across the street from the main entrance. In an interview with the OIG, staff said the website had not been reviewed for several years; however, the Chief of Engineering and Comprehensive Environment of Care Committee co-chair highlighted a navigation project currently in progress, aimed at helping veterans to easily locate

[36] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal*, 1 no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[37] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024.

the facility. Due to the ease of locating the facility entrance, the OIG did not issue a finding in this area.

Throughout the inspection week, the OIG team observed available parking and multiple bus stops with clear signage. The outpatient parking lot also had an overhead canopy with lighting. The OIG team observed that snow had been removed on facility roads, sidewalks, and ramps; however, at both a public transit and a facility shuttle bus stop on campus, snow blocked the pathway to the buses. The OIG expected the pathways to be free of snow, based on VHA policy for staff to ensure a safe environment.[38]

The OIG observed that the facility had adequate transit and parking options but was concerned about the safety and ease of access to the bus stops. The OIG made one recommendation.

Figure 10. *Facility front entrance.*
Source: Photo taken by OIG inspector.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[39]

The OIG team easily identified the facility entrance using signage. The OIG observed that the main entrance was accessible by both a ramp and steps and featured an extended roof above the door, offering a sheltered area for veterans. The entrance area was spacious, had panoramic windows that provided natural light, and space for veterans to socialize and purchase food and drinks. The entrance also had an information desk staffed by volunteers, with wheelchairs available to assist veterans to their appointments.

The OIG team observed an active water leak in the main lobby, resulting from a recent snowfall. Facility staff promptly responded to the issue by placing a bucket to catch the water and a caution sign to alert visitors. The OIG will discuss the leak further in the Repeat Findings section of the report. Despite the active water leak in the main entrance, the OIG's overall impression was the entrance had a positive and welcoming atmosphere. The OIG made no recommendations.

[38] VHA Directive 1608(1).

[39] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[40]

The OIG team noted limited printed materials at the information desk and watched as volunteers provided directions or escorted patients to their appointments. The OIG observed signage throughout the facility that provided building numerical listings and directional arrows but failed to identify which services were in the buildings. For example, the CLC was in building six, but the OIG could not determine this from the signs in the main entrance or parking lot. Based on VA policy, the OIG expected to be able to navigate to the CLC using signage.[41]

The OIG team assessed signage as clear and visible. However, facility leaders should consider clarifying signage by identifying services located in each building. The OIG made one recommendation.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[42] The OIG observed the entrance was equipped with automatic doors activated by a hand-wave motion sensor that a visually impaired veteran might not detect. Facility staff reported they added the door

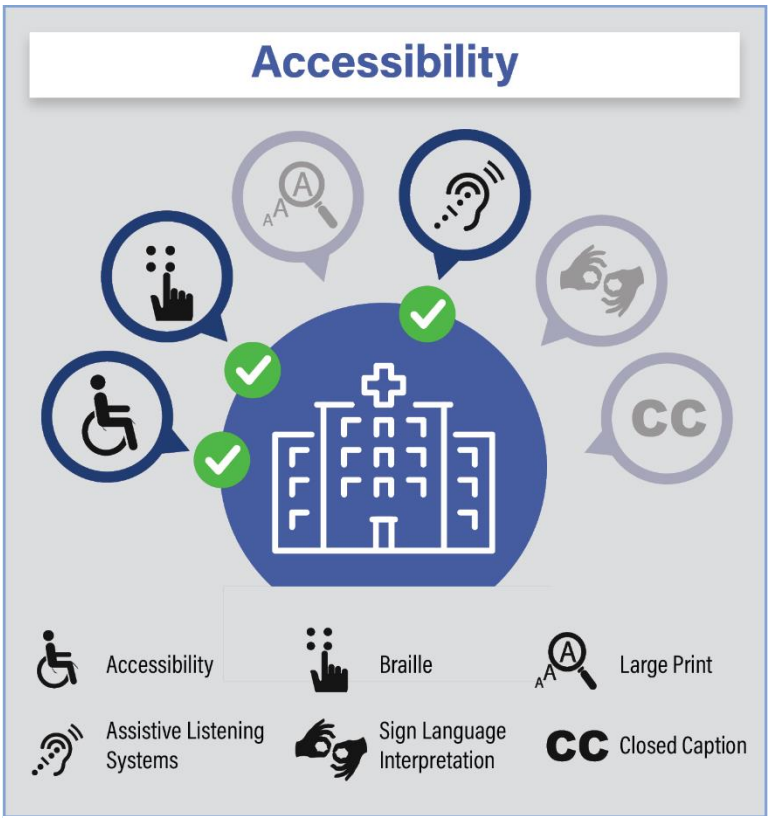


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observation and interviews.

[40] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide.*

[41] Department of Veterans Affairs, *VA Signage PG-18-10 Design Manual*, May 16, 2023.

[42] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

sensor to keep out local wildlife and to limit veterans from touching surfaces to reduce the spread of germs. Facility staff told the OIG that the information desk volunteers did not receive specialized training to assist visually impaired veterans. Facility staff also stated that veterans could be provided an assistive listening device if unable to communicate during an appointment.[43]

Although the facility had multiple accessibility options for sensory-impaired veterans, the OIG identified potential difficulties for those with visual impairments entering the main doors. The OIG made one recommendation.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[44]

The OIG observed a toxic exposure screening poster in the canteen but did not see handouts or outreach information in the main lobby, information desk, or enrollment area. Facility staff reported they provided informational handouts during primary care appointments.

The OIG expected toxic exposure screening materials to be available at facility entry points to enhance veterans' awareness and provide them with easily accessible information. The OIG made one recommendation.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[45]

The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

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[43] An assistive listening device is used to manage hearing in environments by improving the signal to noise ratio and counteracting the impact of distant and poor acoustics. American Academy of Audiology, *The Audiologist's Guide to Hearing Aids, Personal Sound Amplification Products, Hearables, And Over-The-Counter Devices,* January 2018, updated March 2022, https://www.audiology.org/Audiologists-Guide-to-OTCs_Updated-March-2022.pdf.

[44] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022. Department of Veterans Affairs, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[45] Department of Veterans Affairs, *VHA HRO Framework*.

The OIG reviewed the facility comprehensive environment of care quarterly reports and identified stained ceiling tiles throughout the facility as an area needing improvement. The OIG noted stained ceiling tiles in primary and urgent care clinics and the CLC. The OIG also observed an active water leak from the roof in the main lobby. During an interview, staff highlighted a systemic issue with facility-wide roof leakage and discussed a plan for replacement. Staff provided the OIG with documentation identifying funding to replace the roof, but the plan was pending a design by professionals to complete the work.

Facility leaders should continue to address environment of care issues and consider involving Veterans Integrated Service Network staff if needed. The OIG did not make a recommendation because leaders were aware of the problem and had taken action to replace the roof.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and CLC settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG reviewed two CLC units and observed a drainage system in the hallway that engineering staff constructed to prevent water stains from the leaky roof. The drainage system consisted of hoses threaded from the plastic ceiling tiles, extending behind the handrails, and leading into buckets. Although the buckets were not blocking hallways, staff had not labeled the hoses and buckets for caution when using handrails or doorways.

The OIG found the primary and urgent care clinics and the CLC's first floor to be clean, in contrast to the CLC's second floor. On that floor, the OIG observed wall damage in the dining hall, as well as one soiled patient room, which did not contribute to a homelike environment.[46] During the inspection, staff reported entering a work order to repair the wall damage and they cleaned the patient room.

Although the OIG did not make a recommendation, facility leaders and supervisors should consider conducting random visits to the CLC's second floor to check for cleanliness.

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results, the sustainability of

[46] "VA CLCs should have designated spaces for a living room, kitchen and bedroom to reflect a home atmosphere and greater attention to privacy and comfort." VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.

changes made by leaders in response to previous oversight findings and recommendations, and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[47] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[48]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The Associate Chief of Staff for Clinical Diagnostics explained that the process, defined in a standard operating procedure, included several ways for communication of test results, including clinical alert notifications. The Chief of Staff and Chief Informatics Officer agreed that alert fatigue, which occurs when clinical staff become desensitized to safety alerts and miss or do not respond to notifications, was an ongoing challenge for staff. The OIG learned during interviews that staff had completed a project the previous year that significantly decreased the number of alerts to reduce alert fatigue and clinical staff reported positive feedback about the change.

The OIG determined facility leaders had a process to communicate urgent but noncritical test results to ordering providers. The OIG did not identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG made no recommendations.

Action Plan Implementation and Sustainability

Figure 12. *Status of prior OIG recommendations to facility.*
Source: OIG analysis of documents and interviews.

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[49] The OIG evaluated previous facility actions plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

[47] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[48] Daniel R. Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

[49] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

There were no open OIG recommendations. However, internal VA documentation reviewed prior to the OIG's inspection showed one recommendation and corresponding action plan related to the communication of changed test results. The Associate Chief of Staff for Clinical Diagnostics explained that leaders monitored progress through multiple committees.

The OIG determined that facility leaders had implemented a corrective action plan for an open recommendation from an internal VA review and were monitoring the progress of the plan. The OIG made no recommendations.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[50] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[51] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

When interviewing the Chief of Staff, Chief of Quality Management and HRO Lead, Chief Informatics Officer, and other facility staff, the OIG learned staff identified opportunities for improvement through various means, including morning huddles, peer reviews, Ongoing Professional Practice Evaluations, and patient complaints.[52]

The acting Associate Director of Patient Care said frontline staff are involved in process improvement projects. For example, staff shared a story about a new nurse who questioned the laboratory values used to determine whether staff could safely administer an antibiotic. Staff from multiple departments, including nursing, infectious disease, and pharmacy, discussed the issue and reviewed current research to verify safety standards, which resulted in laboratory staff adjusting the values used for safe medication administration. The primary care team Social Worker added that staff also worked with the Systems Redesign Coordinator to develop a new

[50] Department of Veterans Affairs, *A High Reliability Organization (HRO) Reference Guide*.

[51] VHA Directive 1050.01(1).

[52] A huddle is a daily meeting with all members of a team present to "identify and communicate the resolving [of] patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues." "Patient Safety Huddle Board," VHA National Center for Patient Safety, accessed April 2, 2024, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.asp. A peer review "is a critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. "Ongoing Professional Performance Evaluation (OPPE) is the ongoing monitoring of privileged LIPs [licensed independent practitioners] to identify clinical practice trends that may impact the quality and safety of care." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

employee orientation process and could join a daily meeting with quality management staff to learn about other opportunities to participate in process improvement initiatives.

The OIG found the facility had a process to identify improvement opportunities as part of a continuous learning process. The OIG made no recommendations.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[53] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[54] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[55] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The facility liaison reported that within the last 12 months, two primary care team positions were available, one for a clinical associate and another for an administration associate. However, during the week of the OIG inspection, primary care leaders and a Program Analyst said the positions had been filled. The acting Associate Director of Patient Care explained there were no current primary care nursing vacancies because of recruitment incentives and special salary rates. The Chief of Staff added that medical and nurse practitioner residency programs were a good resource for fostering future clinical employees.

The Chief of Staff and acting Associate Director of Patient Care emphasized that primary care leaders created a culture with strong commitments to valuing staff input, addressing issues, and advocating for their teams. The Program Analyst attributed staff retention to engaged leaders, opportunities for growth, and a positive culture.

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[53] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

[54] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

[55] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No 23-00659-186, August 22, 2023.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[56] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[57]

The Program Analyst reported that primary care leaders received a weekly panel management data report. The leaders and the Program Analyst discussed regularly meeting to review the report and adjust staffing as needed to maintain manageable panel sizes. When the OIG asked a group of primary care team members if workloads were reasonable given the staffing levels, members from all disciplines agreed that staffing levels allowed the teams to properly care for their patients. The primary care physician emphasized that despite treating many elderly patients with multiple and complicated medical conditions, the workload and panel size were reasonable.

The OIG found that staffing shortages over the past 12 months did not affect primary care team workflows, and primary care leaders proactively addressed shortages. The OIG also found that facility and primary care leaders kept abreast of staffing issues through reports and meetings and strategically moved staffing resources to ensure reasonable panel sizes. The OIG made no recommendations.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care staff agreed that leaders were supportive and addressed their concerns. For example, staff discussed using multiple software systems to enter the same patient information, which resulted in leaders expanding the informatics department to address the inefficiencies. The Primary Care Nurse Manager shared another example where leaders reduced primary care nurses' workload by having specialty care nurses assist in administering injections to patients.

The OIG found leaders supported primary care team members and made changes based on their concerns. Facility and primary care leaders and team members stated the changes helped improve efficiency. The OIG made no recommendations.

[56] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[57] VHA Directive 1406(1).

[58] VHA Handbook 1101.10(2).

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether there was an impact on primary care delivery. The OIG found veteran enrollment decreased over the three years prior to the inspection. Facility and primary care leaders stated people were moving out of the area due to the increased cost of living. Leaders reported gaining new enrollees, but the additional number of new patients did not equate to the losses.

Facility leaders and primary care team members told the OIG they believed the PACT Act provided an opportunity to reach more veterans and enroll them in primary care. A primary care physician explained that because of the PACT Act, staff needed more time with veterans, but the veterans appreciated the extra attention. All primary care team members said no changes occurred in appointment wait times or availability since the PACT Act implementation.

The OIG found that PACT Act implementation had not resulted in an overall increase in veteran enrollment, longer appointment wait times, or disruption in primary care workflows. The OIG made no recommendations.

The OIG reviewed Health Care for Homeless Veterans (HCHV), Veterans Justice, and Housing and Urban Development-Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[59]

[59] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[60] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[61]

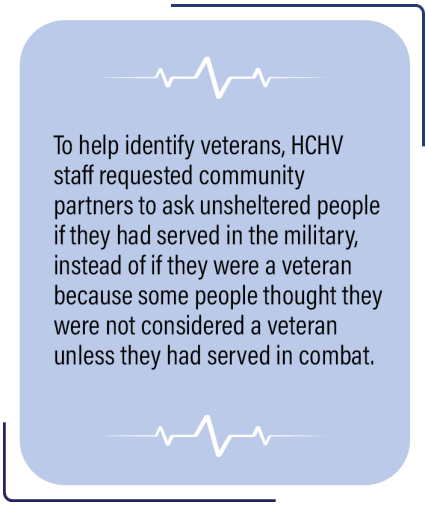

Figure 13. *Best practice for veteran engagement.*
Source: OIG interviews.

The Homeless Program Manager reported that while not the most accurate reflection of unsheltered veterans in the community, staff used the point-in-time count and by-name lists to identify unsheltered veterans.[62] VHA staff may also conduct street and community outreach to identify unsheltered veterans.[63] HCHV staff said they have a small team that serves six counties. Therefore, they did not conduct outreach and instead received referrals through a national call center for homeless veterans and community partners who do street outreach.

The Homeless Program Manager and the HCHV Coordinator reported two barriers in identifying and enrolling veterans: missing vital documents, such as social security cards and birth certificates, and veterans' lack of accessible and affordable transportation to obtain the documents. To address these barriers, the coordinator reported partnering with a community organization to assist with transportation and the local social security office to assist veterans in obtaining the documents.

The OIG found the HCHV staff identified and enrolled veterans into the program and addressed identified barriers to enrollment. The OIG made no recommendations.

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[60] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[61] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.asp.

[62] A by-name-list is "a single prioritized list that is created through the CoCs [Continuum of Care] coordinated entry process." "Using the By-Name List for Housing Prioritization," HomelessData, May 23, 2023, accessed June 24, 2024, https://homelessdata.com.

[63] VHA defines street outreach as "outreach to Veterans experiencing unsheltered, street homelessness taking place in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." Community outreach takes "place in community-based settings such as shelters, meal sites, homeless Veteran Stand Down events, job fairs, resource and referrals centers, and other community outreach events." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[64]

The HCHV program did not meet the HCHV1 target metric in FYs 2021 or 2022 but surpassed it in FY 2023. The program coordinator stated the pandemic and low veteran enrollment contributed to failing to meet the target metric the first two years. The OIG discovered the subsequent success in FY 2023 resulted from veterans receiving Housing and Urban Development-Veterans Affairs Supportive Housing program vouchers and VHA extending the duration a veteran could be away from a residential program without being discharged.

The program did not meet the HCHV2 target metric in FYs 2021, 2022, or 2023. The program coordinator stated that the measure did not accurately reflect their work, as one negative discharge (discharge due to a rule violation) could lower the metric due to the small number of veterans discharged overall. The coordinator described working with community residential program staff to keep veterans enrolled in the program by placing them on written behavioral contracts to prevent negative discharges.

The Homeless Program Manager and the HCHV Coordinator said that aging, frail veterans with complex medical, mental health, and substance abuse issues presented unique challenges with securing permanent housing. Program staff discussed other barriers such as limited housing options and high rental costs in the area, which were unaffordable to veterans on a fixed income. The coordinator reported working with a housing developer to provide affordable housing, even without the housing vouchers.

[64] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

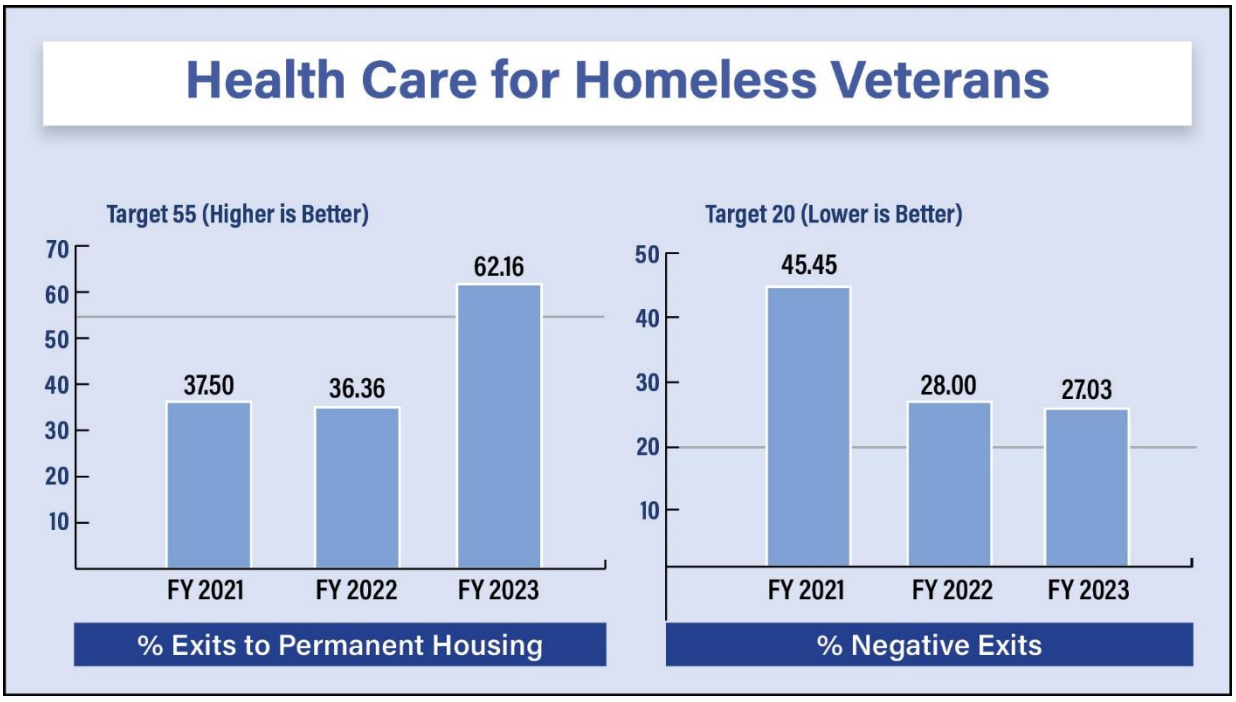

Figure 14. *National metrics for HCHV program.*
Source: OIG analysis of VHA Homeless Performance Measures data.

The OIG found that HCHV staff met the needs of veterans enrolled in the program, were knowledgeable about the program's performance metrics, and were able to discuss challenges meeting VHA targets. The OIG made no recommendations.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[65] Veterans justice programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[66]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering veterans justice programs each fiscal year (performance measure VJP1).[67] During the first three quarters of FY 2023, metrics showed fewer veterans entering the Veterans Justice Program than expected. However, a significant increase in

[65] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*

[66] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[67] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

enrollment in the last quarter of FY 2023 helped the program to meet the overall target for the year. According to the Homeless Program Manager, the current Veteran Justice Specialist was new to the role and developing relationships with community partners during the first three quarters.

The Veteran Justice Specialist reported that the program received referrals from local jails, courts, and facility providers. During interviews, the OIG learned the Veteran Justice Specialist educated parole officers on VA benefits and eligibility and met with incarcerated veterans. Notably, the specialist shared a success story in which a parole officer and homeless program staff assisted an incarcerated veteran transition to a community shelter and enroll in VA services.

The Homeless Program Manager and Veteran Justice Specialist stated staff used the VHA Veterans Justice Programs directive as their local guidance. However, the OIG found that staff had been using an outdated directive and were unaware of the amended directive issued on March 3, 2020.[68] According to staff, they obtained the amended directive and planned to review and implement changes, if needed.

The OIG found that staff provided effective outreach and education for identifying and enrolling veterans in the program. The OIG was concerned that staff were unaware of the updated VHA directive but found the program met overall goals and made no recommendations.

Meeting Veteran Needs

The Veteran Justice Specialist reported identifying veterans release dates from prison and conducting three- and six-month evaluations to determine their needs. The specialist also stated that, after program enrollment, staff assess veterans' needs to determine appropriate treatment, such as admission into a substance abuse program or inpatient mental health care. Then, the specialist and program leaders discuss each veteran's treatment goals, which could include relocating to be closer to family or obtaining employment.

The Veteran Justice Specialist and Homeless Program Manager explained that facility staff planned to implement a national initiative called the deflection program in which Veterans Justice Program staff, facility mental health staff, and VA police will collaborate with local police departments and crisis teams to provide some veterans with alternatives to incarceration. The specialist added that staff had completed training but not yet determined when the program would start.

The Chief, Social Work Services, shared that when the veteran justice specialist position was vacant and pandemic guidelines had suspended in-person visits, community relationships with

[68] VHA Directive 1162.06(1), *Veterans Justice Program (VJP)*, September 27, 2017, amended March 3, 2020. (VHA rescinded this directive and replaced it with VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.)

the criminal justice system had been weakened; however, the Veteran Justice Specialist, had since rebuilt these partnerships. Although the OIG was concerned that veterans may not have received program services during the time the position was vacant, the position had been filled and staff were working to meet veterans' needs.

The OIG concluded that Veterans Justice Program staff were meeting the needs of veterans enrolled in the program. The OIG made no recommendations.

Housing and Urban Development – Veterans Affairs Supportive Housing

Housing and Urban Development-Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[69] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[70]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development-Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[71]

The Housing and Urban Development-Veterans Affairs Supportive Housing Coordinator reported participating in a biweekly meeting involving VSOs, local shelters, local social service departments, and VA staff to identify veterans who were not engaged with VA services. The program did not meet the HMLS3 target metric for FYs 2021 through 2023. The coordinator told the OIG the HMLS3 metric was not an accurate reflection of the program's engagement efforts because it does not reflect the workload involved in the intense case management of unsheltered veterans. The coordinator provided an example of finding permanent housing for a veteran with a history of housing instability, mental health problems, medical conditions, and substance use disorder who exceeded the time limit for temporary housing. Staff met with the veteran weekly and collaborated with community partners, which contributed to the veteran being permanently housed.

[69] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[70] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

[71] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

The coordinator also shared challenges with enrollment that included veterans having the required documentation such as identification, birth certificates, and military discharge papers, and that staff collaborate with community partners to assist veterans if needed. Program staff said the aging population, along with challenges finding landlords willing to rent, were also barriers to meeting the goal. Staff discussed establishing community partnerships to assist veterans with additional housing resources through real estate brokers, as well as helping with housing and moving fees.

The OIG found program staff effectively identified veterans and enrolled them in the program, were knowledgeable about the program's performance metrics, and addressed barriers to enrollment. The OIG made no recommendations.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development-Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[72]

The OIG found the Housing and Urban Development-Veterans Affairs Supportive Housing program did not meet the VASH3 target metric during FY 2022 but had exceeded it by the end of FY 2023. The program coordinator attributed the improved percentage to reviewing documentation quarterly and updating the veterans' employment status in a database. The coordinator stated the program did not require veterans to work, and therefore the VASH3 metric did not accurately reflect the success of the program. Through interviews, the OIG learned that social workers initially met weekly with veterans enrolled in the program and, after several months, tailored the frequency of meetings to the veterans' individual needs.

The OIG found staff met the needs of veterans enrolled in the housing program, noted their strong understanding of the program's performance metrics, and determined staff effectively collaborated with other VA services and community partners.

A community legal service representative notified program staff that a veteran was facing eviction because the housing voucher had expired. Program staff worked with the veteran to expedite the recertification process and kept the veteran in the home.

Figure 15. *Veteran engagement example.*
Source: OIG interviews.

[72] VHA sets the VASH3 target at the national level. For FY 2023, the VASH3 target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

Summary of Findings and Recommendations

The OIG stratified inspection findings using a scoring matrix, based on the severity, frequency, and facility leaders' awareness of the events, and OIG leaders approved them based on content and professional judgment.

- Critical: An actual or potential deficiency in process, practice, or system management that negatively affects the health and safety of veterans, VA and VHA employees, or the public to a catastrophic degree; represents a violation of applicable rules or guidelines; and facility leaders are either unaware or not actively addressing. Any death of a veteran, VA and VHA employee, or member of the public is considered a critical finding.
- Major: An actual or potential deficiency in process, practice, or system management that leads to a negative impact on the health and safety of veterans, VA and VHA employees, or the public; represents a violation of applicable rules or guidelines; and facility leaders may or may not be aware.
- Minor: An actual or potential deficiency in process, practice, or system management that potentially leads to a negative impact on the health and safety of veterans, VA and VHA employees, or the public; represents a violation of applicable rules or guidelines; and facility leaders are aware and addressing.

Major

Finding: The OIG is concerned about the safety and ease of access to buses at the facility.

Recommendation 1: The OIG recommends that facility leaders submit a plan to the OIG detailing steps to address snow removal on pathways leading to and from buses during and after snowstorms.

Finding: The OIG assessed signage as clear and visible; however, signage did not identify the services located in each building for veterans walking through the facility.

Recommendation 2: The OIG recommends that facility leaders consider clarifying signage by identifying the services located in each building to help direct veterans.

Finding: The OIG observed accessibility options for sensory-impaired veterans but identified potential difficulties for those with visual impairments entering the main doors.

Recommendation 3: The OIG recommends that facility leaders implement navigation tools and cues that accommodate visually impaired veterans to help them enter the main doors.

Minor

Finding: Although the OIG determined that staff screened veterans for toxic exposure and provided them with information in the primary care clinics, the information was not available in the main lobby, patient information desk, or enrollment area.

Recommendation 4: The OIG recommends that facility leaders consider distributing toxic exposure screening information where veterans can easily obtain it when entering the facility.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, relevant prior OIG, and an accreditation survey report.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs. Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG inspected the facility from February 12 through February 15, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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 issues.

[1] The All Employee Survey covered the time frame of October 1, 2020, through September 30, 2023. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in August 2021.

[2] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation,* December 2020.

[3] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Race and Ethnicity	Race and Ethnicity	Census population by race/ethnicity are from the Census Redistricting Data (Public Law 94-171) Summary File, US Census Bureau.
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.

Category	Metric	Metric Definition
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented on this report were coded according to International Classification Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.

Category	Metric	Metric Definition
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.

Category	Metric	Metric Definition
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
VHA Staff Retention	Onboard Employees Stay < 1 Year	VA's All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the facility in context figures quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 23, 2024

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Healthcare Facility Inspection of the VA Hudson Valley Healthcare System in Montrose, New York

To: Director, Office of Healthcare Inspections (54HF04)

Director, GAO/OIG Accountability Liaison (10OIC Goal Action)

I have reviewed the responses to the OIG HFI recommendations from Hudson Valley Health Care System. I concur with the recommendations, the written responses and with their request for closure of recommendations #1 & 4.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA FACEP
VISN 2 Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 22, 2024

From: Director, VA Hudson Valley Healthcare System (620)

Subj: Healthcare Facility Inspection of the VA Hudson Valley Healthcare System in Montrose, New York

To: Director, New York/New Jersey VA Health Care Network (10N2)

As the Medical Center Director, I have reviewed the responses to the OIG HFI recommendations. I concur with the written responses and also concur in requesting closure of two of the four items.

(Original signed by:)

Gary Poole
Associate Medical Center Director
For
Dawn Schaal
Medical Center Director

Appendix E: VA Responses

Recommendation 1

The OIG recommends that facility leaders submit a plan to the OIG detailing steps to address snow removal on pathways leading to and from buses during and after snowstorms.

___X__Concur

_____Nonconcur

Target date for completion: August 14, 2024

Director Comments

The Grounds Operation Standard Operating Procedure was amended to address snow removal on pathways leading to and from buses. The Chief of Environmental services will inform staff and will also verify that, when snow removal is required, that the bus stops have been cleared of snow. We request closure of this item.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The OIG recommends that facility leaders consider clarifying signage by identifying the services located in each building to help direct veterans.

___X__Concur

_____Nonconcur

Target date for completion: November 30, 2024

Director Comments

Signs will be constructed and posted to identify the services located in buildings and to direct people to the appropriate parking areas. The signage will indicate the location of the community living centers and the outpatient services and will direct vehicles to convenient parking.

Recommendation 3

The OIG recommends that facility leaders implement navigation tools and cues that accommodate visually impaired veterans to help them enter the main doors.

___X__Concur

_____Nonconcur

Target date for completion: November 30, 2024

Director Comments

Volunteers at the main entrance will be trained to assist visually impaired Veterans in opening the entrance door. This training will be conducted by low vision staff in coordination with the Chief of Voluntary Services.

Recommendation 4

The OIG recommends that facility leaders consider distributing toxic exposure screening information where veterans can easily obtain it when entering the facility.

___X__Concur

_____Nonconcur

Target date for completion: August 14, 2024

Director Comments

The Toxic Exposure Screening brochures have been distributed to Veteran Information distribution stations throughout the campus, including the main entrance. The Veteran Health Education Coordinator from the education department is responsible for ensuring that all brochures are stocked and review the information distribution stations on a regular basis. We request closure of this item.

OIG Comments

The OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

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