US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky

Healthcare Facility Inspection	24-03205-235	October 17, 2025

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review 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 physically inspected the VA Louisville Healthcare System (facility) from October 1 through 3, 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, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders described two system shocks, a main water line break and problems with the telephone system. Leaders discussed that while waiting for the water line repairs, staff had to find ways to ensure all areas had the necessary water and supplies to support veterans and staff, which included borrowing and renting resources to maintain operations, such as a portable handwashing sink.

Leaders reported a telephone system upgrade highlighted previously unknown vulnerabilities, which allowed veterans to bypass the main facility phone number and directly contact individual staff members. This resulted in calls to unmonitored lines outside of business hours and unassigned voicemails. The OIG is concerned that leaders were unaware of the vulnerabilities of

[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.

their prior phone system and did not take steps to evaluate the system before the upgrade and made a recommendation.

Additionally, the OIG learned about a veteran who had died by suicide on facility grounds. The OIG referred the issue to its hotline management team for further review.

To assess staff satisfaction with the facility, the OIG reviewed All Employee Survey results for fiscal years (FYs) 2022 through 2024.[2] Leaders acknowledged the results were lower than VHA averages and attributed this to new, less experienced service chiefs who needed to learn how to better communicate information to their employees. Additionally, leaders shared new service chiefs received training on mentoring, communication, leadership, and accountability.

During the inspection, the OIG received numerous complaints from employees about psychological safety and fear of reprisal.[3] Additionally, the facility had one of the lowest FY 2024 Organizational Health Index scores in VHA.[4] Facility leaders should evaluate employees' perceptions of psychological safety and fears of reprisal and implement strategies to improve.

Environment of Care

The OIG examined the general entry touchpoints (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 also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The OIG confirmed concerns from patient advocate reports about difficulties related to signs.[5] For example, the OIG found an incorrect navigation sign that did not lead to the surgical intensive care unit and an exit sign that did not lead to an exit.[6] Facility leaders should review internal navigational signs for accuracy and the OIG recommends they ensure exit signs lead to

[2] 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.

[3] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." 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.

[4] The Organizational Health Index is a summary of the overall differences in All Employee Survey scores for each facility compared to VHA averages and the facility's prior year. The VA Louisville Healthcare System was one of five facilities that scored negative 67 for this index in FY 2024, which was the lowest score overall in VHA.

[5] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[6] "The exit access must not go through a room that can be locked, such as a bathroom, to reach an exit or exit discharge, nor may it lead into a dead-end corridor." 29 C.F.R. § 1910.37 (2025).

an exit. Additionally, the OIG observed that external navigation signs were not easily visible in the dark. Facility leaders should review the need to improve their visibility.

The facility had tools available for veterans with sensory impairments, but the OIG observed multiple crosswalks without detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel), and common area televisions did not consistently use closed captioning.[7] The OIG recommends facility leaders install detectable warning surfaces. They should also use closed captioning on all common area televisions.

During the physical inspection, the OIG identified areas that lacked a safe, clean, and functional environment. For example, the OIG observed damaged furniture, stained ceiling tiles, dirty ice machines, and dust on parts of bed frames and sprinkler heads. Additionally, the OIG found multiple electrical cords connected to unsecured power strips, lying across the floor, or hanging over a stretcher, and recommends leaders keep patient areas safe and clean.[8]

The OIG also identified biohazard rooms lacking the appropriate signs, and clean and dirty equipment stored together.[9] Additionally, the OIG learned a subcontractor had not disposed of biohazard waste from community-based outpatient clinics. The OIG recommends staff address these deficiencies.

In addition, the OIG found a blanket warmer with a slightly higher temperature than the maximum, and staff did not enter a request for its repair until the OIG visit in October 2024. The OIG did not make a recommendation but encourages leaders to make sure all blanket warmers are at or below the maximum temperature.

The OIG also found a nonfunctioning environmental alarm in a supply room where liquid nitrogen was used and stored.[10] Although the OIG could not find a requirement to have an alarm monitor for this type of room, facility staff installed the alarm, and therefore the OIG expects they will have an alternate plan in place to ensure safety. The OIG also found a small device containing liquid nitrogen unmonitored in an examination room and recommends leaders ensure staff address this vulnerability. Despite a VHA requirement, the OIG also found the Environment

[7] "Install Detectable Warning Surfaces anywhere a walkway transitions into a vehicle roadway." VA Manual PG 18-10, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

[8] Exposed cords on the floor can lead to a trip and fall incident. Department of Health and Human Services, *Slip, Trip, and Fall Prevention for Healthcare Workers*, December 2010, https://www.cdc.gov/niosh/2011-123.pdf.

[9] For biological hazard signs, "the biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents." 29 C.F.R. § 1910.145 (2013).

[10] Liquid nitrogen is a hazard due to being a simple asphyxiant ("a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed") and if not used properly, can result in injury or death. 29 C.F.R. § 1910.1200 (2024). The Joint Commission expects hospitals to monitor levels of hazardous gases. The Joint Commission, *Standards Manual*, E-dition, EC 02.02.01, August 1, 2024.

of Care Committee had not identified at least one facility-specific environment of care trend to monitor and made a recommendation.[11]

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 recommendations; and implementation of continuous learning processes to identify opportunities for improvement. VHA requires facility staff to develop a policy and service-level workflows for the communication of patient test results.[12] The OIG reviewed the facility policy and standard operating procedures for service-level workflows and found not all services have a workflow. The OIG also found the policy identified Emergency Department providers as the primary recipients to receive after-hours communication of critical test results, contrary to a VHA directive.[13] The OIG recommends that facility leaders review the policy to ensure it complies with VHA requirements and staff ensure each service has a service-level workflow.

VHA requires facility leaders to ensure staff review performance metrics for the communication of test results and take corrective actions when needed.[14] The OIG reviewed the FY 2024 performance metrics for these communications and identified negative trends. The OIG also reviewed executive leader meeting minutes and documents from a quality management staff member but could not confirm staff reported the performance metrics to leaders. The OIG recommends facility leaders develop a formal process to track test result performance metrics and implement improvement actions, and report compliance to an appropriate oversight committee.

The OIG interviewed the Acting Patient Safety Manager to determine how facility staff identify and monitor adverse events. The acting manager reported reviewing adverse events daily, communicating them to executive leaders the following day, then sharing them with service chiefs and managers to develop action plans, and monitoring their progress. If plans are past due, the acting manager reported verbally communicating this information to executive leaders but acknowledged there was no formal process to report overdue action plans to them. The OIG did not make a recommendation, but executive leaders should consider creating a formal process.

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[11] Acting Assistant Under Secretary for Health for Support (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024.

[12] VHA defines a service-level workflow as "a written document that describes the processes for communicating test results for each clinic, service, department, unit or other point of service where tests are ordered." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[13] "The ED [emergency department] must not serve as the default location for off-tour [outside of normal business hours] reporting of new emergent and imminently life-threatening test results without mechanisms to allow notification to the VA medical facility ordering provider or designee." VHA Directive 1088(1).

[14] VHA Directive 1088(1).

The OIG also reviewed patient safety events that occurred during the 12 months prior to the inspection and found a trend with delays in diagnostic imaging providers communicating test results to providers who order tests. During an interview with the Chief of Radiology, the OIG learned the delays involved images staff sent to the National Teleradiology Program office for review.[15] The Chief of Radiology explained that staff sent the images to this program outside of normal business hours, and the national program had experienced staffing shortages. The chief added they also used a Veterans Integrated Service Network-contracted service and the University of Louisville for additional diagnostic imaging service support.[16]

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected primary care delivery structure and new patient appointment wait times.[17]

The OIG found that almost half the primary care teams exceed recommended panel sizes (the number of patients assigned to a care team), and many others are close to capacity.[18] The facility has 40 primary care teams, and the Chief of Staff expects executive leaders to approve hiring two teams in the next year.

Additionally, the OIG noted new patient appointment wait times had increased from 12 days in quarter one FY 2023, to 28 days in quarter three FY 2024. Staff and leaders acknowledged existing staffing challenges and excessive panel sizes had decreased patients' access to care and satisfaction and increased employee workload. The OIG recommends facility leaders manage panel sizes to ensure patients have timely access to high-quality care.

The Associate Chief of Staff for Ambulatory Care (primary care) stated that workload is the biggest challenge for primary care staff because of the high volume of patient information that teams must review. Staff discussed challenges with workload that reduces time they spend with patients.

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[15] "NTP [National teleradiology program] provides 24/7 diagnostic radiology services to Department of Veterans Affairs (VA) medical facilities located in all Veterans Integrated Service Networks (VISNs)." VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

[16] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

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

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

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The facility met the performance metrics for the percentage of veterans discharged to permanent housing for FYs 2022 and 2023, as well as for those who left the program due to a rule violation, failure to meet program requirements, or without notice in FY 2023. Program staff attributed the program's successes to outreach and case management, in addition to soliciting feedback from veterans and community partners. Staff described using a facility-wide care coordination process to request services for veterans and collaborating with over 30 different community partners.

The Housing and Urban Development–Veterans Affairs Supportive Housing program consistently exceeded the employment performance target from FYs 2021 through 2023. The program lead attributed this success to a cohesive team of 21 dedicated staff, adding that outreach efforts included weekly meetings with community partners and Health Care for Homeless Veterans program staff. However, the Housing and Urban Development–Veterans Affairs Supportive Housing program was unsuccessful in meeting the performance target for assigning housing vouchers in FYs 2022 and 2023. Program staff expressed a belief that this was due to limited affordable housing, and re-housing some veterans multiple times. The staff described their efforts to overcome these barriers by identifying additional affordable housing, collaborating with community partners for financial assistance with housing-related costs, and exploring creative options such as housing veterans together.

The facility's Veterans Justice Program exceeded the target for identifying and enrolling veterans in FY 2023. Program staff identified veterans by collaborating with legal clinics, jail staff, attorneys, and court liaisons. Staff added they work with multiple veterans treatment courts to support veterans through the judicial process and link veterans to treatment, housing, and employment to meet individual needs.[19]

[19] "A Veterans Treatment Court is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

What the OIG Recommended

The OIG made 13 recommendations.

1. The Executive Director oversees improvements to the telephone system to ensure identified vulnerabilities are addressed.
2. Facility leaders ensure exit signs lead to an exit.
3. Facility leaders install detectable warning surfaces anywhere a walkway transitions into a roadway.
4. The Executive Director ensures staff keep patient care areas clean and safe.
5. Facility leaders ensure staff conduct a risk assessment for electrical cord management to identify and implement any needed improvements.
6. The Executive Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present and store clean and dirty items separately.
7. The Executive Director ensures prompt disposal of biohazardous waste.
8. Facility leaders ensure staff conduct a risk assessment on liquid nitrogen use and storage, to include devices in exam rooms, and implement changes accordingly.
9. The Executive Director ensures the Comprehensive Environment of Care Committee identifies at least one facility-specific environment of care trend and establishes a performance improvement plan, including outcome measures, to address it.
10. Facility leaders ensure staff develop service-level workflows for the communication of test results for each service.
11. Facility leaders review the test result communication policy to ensure it complies with the VHA requirement for communicating critical results outside of normal business hours.
12. Facility leaders develop a formal process for staff to track performance metrics for test result communication, implement improvement actions, and report compliance to an appropriate oversight committee.
13. Facility leaders manage panel sizes to ensure patients have timely access to high-quality care.

VA Comments and OIG Response

The acting Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans, and leaders are implementing corrective actions (see OIG Recommendations and VA Responses). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 Louisville Healthcare System
Louisville, Kentucky
Level 1b-High Complexity
Jefferson County
Hospital Referral Region: Louisville

Description of Community

POPULATION

Female **1,188,678**	Male **1,150,432**
Veteran Female **16,038**	Veteran Male **140,934**

Homeless - State **3,984**

Homeless Veteran - State **328**

MEDIAN INCOME

$52,905

EDUCATION

85% Completed High School

54% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **89**

SUBSTANCE USE

23.1% Driving Deaths Involving Alcohol

16.4% Excessive Drinking

1,014 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+

4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	877,353
Carpool	95,897
Work at Home	60,056
Walk to Work	17,285
Other Means	13,380
Public Transportation	11,729

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**31 Minutes, 26.5 Miles**
Specialty Care	**60.5 Minutes, 56 Miles**
Tertiary Care	**95 Minutes, 93.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 21,775

Veterans Receiving Telehealth (Facility)	43%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	13%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

16,648

258 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.21 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
23	36

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	57K
Unique Patients VA Care	55K
Unique Patients Non-VA Care	20K

COMMUNITY CARE COSTS

Unique Patient $26,537	Outpatient Visit $318
Line Item $1,178	Bed Day of Care $376

STAFF RETENTION

Onboard Employees Stay <1 Yr	14.80%
Facility Total Loss Rate	14.78%
Facility Retire Rate	2.89%
Facility Quit Rate	10.04%
Facility Termination Rate	1.77%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.05% 3.38% 6.71% 10.04% 13.36% 16.46%

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) 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 the Healthcare Facility Inspection cyclical review program to help accomplish its mission. Inspection 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 (VA), "VHA's Journey to High Reliability."*

Healthcare Facility Inspection 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 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.

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

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]

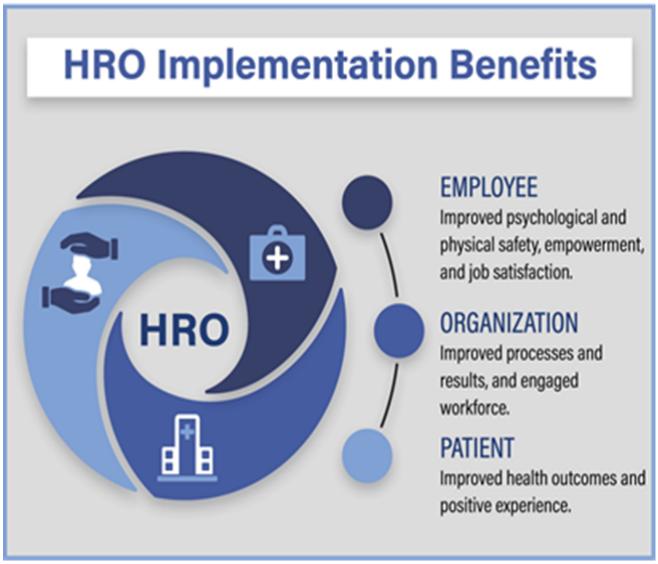

Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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]

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 inspectors observed how facility leaders incorporated high reliability principles into their operations.

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

[3] Veazie, Peterson, and 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 in April 2023.

[6] "VHA 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.)

[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.

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.

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

[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 (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Content Domains

Figure 3. *Healthcare Facility Inspection'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; 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(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

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 Robley Rex VA Medical Center of the VA Louisville Healthcare System (facility) opened in 1952. The Associate Director of Operations explained that in fiscal year (FY) 2024, the facility's budget was approximately $758 million, not including about $32 million allocated for a new facility that is estimated to open in 2026. The ADPCS said the current facility has 111 operating beds (95 hospital and 16 domiciliary).[13] The Associate Director for Resources stated that once complete, the current facility will be closed and the new facility will have more parking spaces and 104 operating beds.

The OIG inspected the facility from October 1 through 3, 2024. The facility's executive leaders consisted of the Executive Director (Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director of Operations, and Associate Director for Resources. The newest member of the leadership team, the Associate Director for Resources, was assigned in April 2023, when leaders created the position. The ADPCS reported being appointed in January 2016 and was the most tenured.

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, 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, and both employees' and veterans' experiences. The OIG administered a

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 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.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

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] 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. Executive leaders described system shocks as telephone system issues and a main line break from the facility's water tower.

The Director explained the recent phone system upgrade was a shock because it revealed vulnerabilities with the previous system that leaders had been unaware of. These included routing options that allowed veterans to bypass the main facility phone number and directly contact individual staff members or reach unmonitored lines outside of business hours; some calls lead to unassigned voicemails, which could delay patient care. The issues persisted with the new system.

Leaders shared their belief that staff provided phone numbers to veterans and caregivers so they could contact them directly. VHA requires the medical facility director to ensure veterans have "a VA medical facility toll-free telephone number" to reach trained staff who can provide "health care services 24 hours a day, 7 days a week."[19] Leaders acknowledged the phone system upgrade is an ongoing opportunity for improvement. They described actions they have already taken, including creating a phone system workgroup, whose first update to leaders was due within a month after the OIG's site visit in October 2024. However, the OIG is concerned that executive leaders did not evaluate the prior system before implementing the upgrade and were unaware of its vulnerabilities.

The OIG recommended the Director oversees improvements to the telephone system to ensure identified vulnerabilities are addressed. The Director responded to the recommendation and

[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.

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

[18] 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] VHA Directive 1090, *Telephone Access for Clinical Care*, September 20, 2023.

reported staff established a single phone number, organized the phone lines into specific branches, and simplified the options for veterans when they call (see OIG Recommendations and VA Responses).

The OIG also reviewed information and learned of a veteran suicide on facility grounds. The OIG referred the issue to its hotline management team for further analysis.

Leaders said another system shock was a break in the main line from the facility's water tower on a weekend, which staff identified immediately; however, due to the size of the line, it resulted in outdoor flooding, loss of water reserves, and some damage to outside areas such as the parking lot and road. Leaders further explained this issue was complicated by the inaccessibility of the water line shut-off valve, which was blocked by a room that had been constructed sometime after the placement of the valve. Leaders elaborated on how staff worked hard during this emergency to ensure they had supplies and equipment to continue supporting patient care. For example, staff provided bottled water to patients and staff, used plastic utensils and paper products that did not require washing, borrowed portable handwashing sinks from another VHA facility, routed water to inpatient restrooms, and supplied portable toilets in other areas. Staff also sent patients needing emergency care to nearby hospitals. Following the event, leaders said staff moved the shut-off valve to a more accessible location; the OIG observed completed repairs to outside areas.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] 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 culture.[21] 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."[22] The OIG

SENIOR LEADER COMMUNICATION AND INFORMATION SHARING

Leaders said they communicated with employees through several methods, including emails, tiered huddles (focused daily conversations between employees and leaders), weekly fireside chats (facility town halls), and monthly leader rounding (visits to various locations across the facility).

Figure 4. *Leader communication with staff.*
Source: OIG interviews with facility leaders.

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

[21] 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*.

[22] 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.

reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with employees, and shared information.[23]

The OIG found the facility's survey results for senior leader communication, information sharing, and transparency were lower than VHA's averages for FYs 2022 through 2024. The leaders said many of the service chiefs were new with limited leadership experience and needed to learn how to better articulate information to employees. The leaders stated they trained new chiefs on effective communication, mentoring, leadership, HRO principles, and having conversations with employees about accountability. Leaders also said they used survey data as part of the HRO journey, which they have been on for approximately four years.

On May 31, 2024, Veterans Integrated Service Network (VISN) and medical facility directors received VHA guidance to reduce overall staff numbers due to the budget.[24] Leaders stated they communicated frequently with employees regarding their plans to meet the revised staffing budget. The Director acknowledged the guidance requires leaders to make strategic hiring decisions to meet budget expectations.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26] 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. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

The OIG found that FY 2024 scores for no fear of reprisal and workgroup psychological safety were lower than the FY 2023 facility scores and FY 2024 VHA average scores. Despite the lower survey results, leaders said they believe employees feel psychologically safe based on the

[23] 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.

[24] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/. Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO Program Office Leadership, May 31, 2024.

[25] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." 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.

[26] 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.

increased number of those who report their own errors. The Associate Director shared an example of a patient event involving a wrong-site surgery in which leaders brainstormed with staff about how to prevent similar errors in the future. Leaders said they believed their transparency enhanced employees' psychological safety across the facility.

However, during the inspection, the OIG received numerous complaints from employees about psychological safety and fear of reprisal. The facility also had one of the lowest Organizational Health Index scores in VHA for FY 2024.[27] Facility leaders should evaluate employees' perceptions of psychological safety and fears of reprisal and implement strategies to improve.

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.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In response to an OIG questionnaire, the patient advocates stated veterans had phone challenges such as long wait times or not being able to get through to a person. The Director noted awareness of the ongoing issues after the phone system upgrade. Executive leaders said they have a rapid process improvement project in progress to address the phone issues.

Leaders said they have monthly town halls where they share and discuss information with veterans. Leaders described multiple veterans who expressed support and complimented the facility during the town halls.

[27] The Organizational Health Index is a summary of the overall differences in All Employee Survey scores for each facility compared to VHA averages and the facility's prior year. The VA Louisville Healthcare System was one of five facilities that scored negative 67 for this index in FY 2024, which was the lowest score overall in VHA.

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

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

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.[30] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (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 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 inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 5. *Facility photo.*
Source: "VA Louisville Health Care," Department of Veterans Affairs, accessed September 18, 2024, https://www.va.gov/louisville-health-care/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[31] 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, and Architectural Barriers Act 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.[32]

[30] VHA Directive 1608(1).

[31] 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.

[32] 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; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

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.

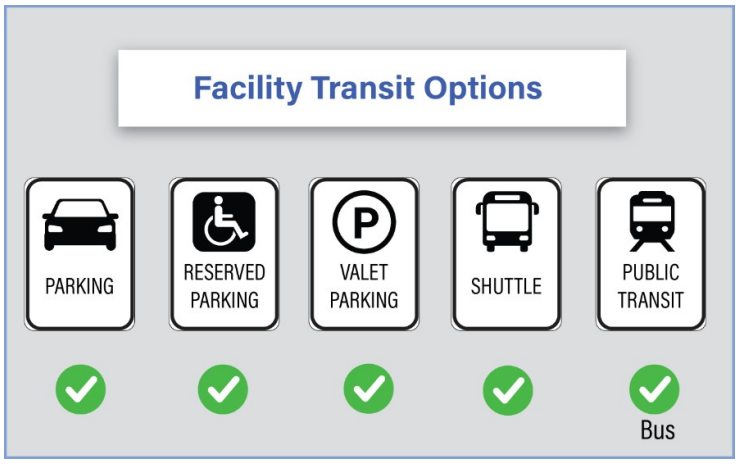

Figure 6. *Transit options for arriving at the facility. Source: OIG analysis of documents.*

The OIG used a commercial navigation application to travel to the facility and found the directions easy to follow. On arrival, the OIG observed signs directing veterans where to park; however, the signs were not easily visible in the dark (see appendix C, figure 1). Although patient advocate reports revealed parking concerns, specifically a lack of spaces close to the entrance, the OIG found the facility offered complementary valet parking and a shuttle service to facilitate access to the medical center building. Facility leaders should review the need to improve the visibility of exterior signs, especially at night.

Main Entrance

Figure 7. *Statue of camouflage horse with prosthetic leg outside the Robley Rex VA Medical Center. "No Less a Thoroughbred" by artists: Don Colon, Ivan Colon, Austin Colon, and Scott Brittingham. Source: Photo taken by OIG inspector.*

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.[33]

The OIG found the facility's Robley Rex VA Medical Center had three commonly used entrances, referred to as the east, west, and clinic entrances. The entrances all had a passenger loading zone, power-assisted doors, and a supply of wheelchairs. The east and west entrances had information desks operated by volunteers or employees to assist veterans with directions, and the clinic entrance had a coffee shop just inside the doors. The clinic entrance also included access to the Emergency Department and had an exterior drive-up ramp and area for ambulance pickup or drop-off.

[33] 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*.

Outside the clinic entrance on the ramp, however, the OIG observed an active construction site, and the ramp remained open and accessible to the public. The ramp also had a construction worker in a forklift, as well as an unattended ladder leading to the roof. There was no clear barrier around the forklift or ladder and no staff present on the ramp to ensure safety (see appendix C, figures 2–5).[34] This could result in unauthorized individuals accessing a potentially dangerous area or a vehicle on the ramp hitting the forklift or ladder. The Chief of Engineering Service reported the ramp area should have a construction staff member monitoring traffic flow and ensuring safety at the site. After the OIG informed facility leaders of these safety concerns, the Associate Director for Resources said staff stopped construction and it would not resume until they addressed the safety concerns; the OIG noted the equipment was no longer there.

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.[35]

The OIG observed kiosks that have electronic maps with a barcode veterans could scan to access the maps on their personal devices. The OIG noted the electronic maps for internal facility navigation were generally up-to-date and provided users with turn-by-turn directions. However, the OIG's review of patient advocate reports revealed veterans had concerns with signs. The OIG followed the internal navigational signs to various locations and found opportunities for improvement. For example, despite signs to the surgical intensive care unit, staff told the OIG it was now a medical surgical unit and all critical care units were in a different location. Additionally, the OIG found an exit sign that did not lead to an exit, which could prevent someone from finding a safe way out of the building during an emergency.[36] Facility leaders should review internal navigational signs for accuracy and update them as needed. The OIG also recommends facility leaders ensure exit signs lead to an exit.

[34] "The entire perimeter of the construction site should be protected either through fencing or other barrier that prevents or restricts access by unauthorized persons." VHA Healthcare Environment and Facilities Programs (HEFP), *Construction Safety Guidebook*, February 29, 2024. Portable ladders "are guarded by a temporary barricade, such as a row of traffic cones or caution tape, to keep the activities or traffic away from the ladder." 29 C.F.R. § 1910.23 (2019).

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

[36] "The exit access must not go through a room that can be locked, such as a bathroom, to reach an exit or exit discharge, nor may it lead into a dead-end corridor." 29 C.F.R. § 1910.37 (2025).

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] The OIG found multiple crosswalks that lacked detectable warning surfaces where the walkway transitioned onto the roadway, which alert those with visual impairments of their approach to vehicular traffic.[38] The OIG recommends facility leaders install detectable warning surfaces anywhere a walkway transitions to a roadway.

The OIG observed multiple internal building features to assist those with visual impairments navigate the facility, including an electronic map with large print, and raised braille symbols on signs. Additionally, information desk staff reported they assist persons with visual impairments to their locations.

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

Information desk staff also explained they communicate to individuals with hearing impairments through writing, and one volunteer reported using sign language. The OIG observed televisions in multiple common areas, but they did not consistently use closed captioning to accommodate individuals with hearing impairments. Facility leaders should use closed captioning on common area televisions.

Toxic Exposure Screening Navigators

VA recommends that each facility 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.[39] The OIG noted the facility has two toxic exposure screening navigators. Although both reported having other primary job duties, one navigator clarified they

[37] 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.

[38] "Install Detectable Warning Surfaces anywhere a walkway transitions into a vehicle roadway." VA Manual PG 18-10, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

[39] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

have adequate resources to complete current responsibilities, which included acting as a subject matter expert and coordinating screenings at the facility. The OIG learned multiple staff conduct toxic exposure screening outreach activities at the facility and in the community.

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.[40] 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. The OIG did not identify any repeat environment of care findings for the areas evaluated.

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 community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected several clinical areas and noted clear exit paths, generally clean floors, and medical equipment with evidence of current preventative maintenance.[41] However, the OIG also found unclean and unsafe areas.[42] For example, the OIG noted dust on bed frames beneath the mattresses, on examination tables, and on some sprinkler heads; as well as broken drawers and a chair with torn upholstery, stained ceiling tiles, and dirty ice machines. The OIG also found multiple occurrences in several locations where electrical cords were connected to unsecured power strips lying across the floor and, in one place, hanging over a stretcher, which poses a hazard to patients and staff.[43]

The OIG recommended the Director ensures staff keep patient care areas clean and safe. The OIG also recommended facility leaders ensure staff conduct a risk assessment for electrical cord management and implement any needed improvements. The Director responded to the recommendations and reported staff began to monitor electrical cord power strips, torn furniture, and ice machines during environment of care rounds, and now report these issues to the

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

[41] The facility did not have a community living center.

[42] The Joint Commission standard requires that the facility "establishes and maintains a safe, functional environment." The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, August 1, 2024.

[43] Exposed cords on the floor can lead to a trip and fall incident. Department of Health and Human Services, *Slip, Trip and Fall Prevention for Healthcare Workers*, December 2010, https://www.cdc.gov/niosh/2011-123.pdf.

Comprehensive Environment of Care Committee. Leaders also contracted with a fire sprinkler inspector, who completed an initial sprinkler head cleaning. In March 2025, engineering staff received training on the proper use of electrical cord power strips and in September 2025, facility staff completed a risk assessment for electrical cord management (see OIG Recommendations and VA Responses).

Further, the OIG noted some areas where biohazardous items were stored lacked required biological hazard signs.[44] The OIG also noted staff stored clean and dirty equipment in the same rooms, and many of these rooms were cluttered.[45] Additionally, a staff member notified the OIG that a subcontractor had stopped removing biohazardous waste from the community-based outpatient clinics, which resulted in the waste accumulating for weeks.[46] The Associate Director for Resources explained the pickups stopped when they notified the contractor in mid-September 2024 that they might run out of funds before the end of the month (the end of FY 2024). Although the Associate Director reported they funded and renewed the FY 2025 contract, the subcontractor had not resumed picking up the waste.

Once facility leaders became aware of this situation in the first weeks of October 2024, they discovered the contractor had not paid the subcontractor. Leaders referred this payment issue to the Office of General Counsel, and in the interim, staff removed the waste from the clinics in Kentucky and leaders paid a vendor to remove the waste from clinics in Indiana.

The OIG recommended the Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present and store clean and dirty items separately. The OIG also recommended the Director ensures prompt disposal of biohazardous waste. The Director responded to the recommendations and reported that staff posted biological hazard signs on most doors by July 2025. Leaders also awarded a new disposal contract in August 2025 and the contractor began scheduled pickups(see OIG Recommendations and VA Responses).

Additionally, the OIG found a blanket warmer that was programmed to a maximum of 130 degrees Fahrenheit but had a slightly higher temperature reading. The OIG reviewed documentation showing that staff checked the temperature daily. However, staff said they did not know how to adjust the temperature, so they propped open a door to lower the warmer's

[44] For biological hazard signs, "the biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents." 29 C.F.R. § 1910.145 (2013).

[45] Soiled and contaminated supplies are separate from clean and sterile supplies. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

[46] "To make access to health care easier, VHA utilizes Community-Based Outpatient Clinics (CBOC) across the country. These clinics provide the most common outpatient services, including health and wellness visits, without the hassle of visiting a larger medical center." "Veterans Health Administration, About VHA," Department of Veterans Affairs, accessed October 28, 2024, https://www.va.gov/health/aboutVHA.asp. The Joint Commission expects hospitals to have procedures for "prompt disposal of trash and regulated medical waste." The Joint Commission, *Standards Manual*, E-dition, EC 02.02.01, August 1, 2024.

temperature when they saw it was over 130 degrees Fahrenheit. Staff did not submit a request for its repair until the OIG was on-site. The OIG did not make a recommendation but encourages facility leaders to evaluate all blanket warmers and ensure they do not exceed the maximum temperature to reduce the risk of harming patients.[47]

In another area, staff told the OIG the supply room had an alarm to monitor the environment for safe use and storage of liquid nitrogen, but the alarm had malfunctioned several weeks earlier.[48] Staff said they had removed the alarm while waiting for a replacement sensor to arrive and confirmed the room was currently unmonitored. The OIG could not find a requirement to have an alarm for a room with this amount and type of material; however, because facility leaders had determined it was necessary to monitor, the OIG expects staff to have an alternate plan to ensure safe use and storage. The OIG also found a small device containing liquid nitrogen used for patient care left unmonitored in an examination room, which could harm patients if they tried to use it.

The OIG recommended facility leaders ensure staff conduct a risk assessment on liquid nitrogen use and storage, to include devices in exam rooms, and implement changes accordingly. The Director responded to the recommendation and reported staff completed a risk assessment of the liquid nitrogen area and plan to monitor the space regularly (see OIG Recommendations and VA Responses).

Additionally, VHA requires the Comprehensive Environment of Care Committee to identify at least one facility-specific environment of care trend and develop a performance improvement plan, with outcome measures, to address it.[49] However, the OIG found the committee had not identified a trend to monitor. The Safety Manager said tracking other environmental measures, such as water management, met the requirement, but the Associate Director of Resources confirmed the committee had not identified a trend. The OIG recommends the Director ensures the Comprehensive Environment of Care Committee identifies at least one facility-specific environment of care trend and establishes a performance improvement plan, including outcome measures, to address it.

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[47] "Best practice would utilize evidence-based guidelines and recommendations by organizations such as but not limited to AORN [Association of periOperative Registered Nurses] and ECRI to determine optimal and safe temperatures for blankets to be warmed to. Both AORN and ECRI recommend maximum temperature setting of 130 degrees Fahrenheit (54 degrees Celsius) for blanket warming cabinets." "What Standards Apply to the Requirement for Organizations to Maintain Blanket Temperatures?, Medical Equipment–Blanket Temperature Risk Assessment," The Joint Commission, accessed November 26, 2024, https://www.jointcommission.org/faqs.

[48] Liquid nitrogen is a hazard because it is a simple asphyxiant ("a substance or mixture that displaces oxygen in the ambient atmosphere, and can thus cause oxygen deprivation in those who are exposed") and if not used properly, can result in injury or death. 29 C.F.R. § 1910.1200 (2024). The Joint Commission expects hospitals to monitor "levels of hazardous gases." The Joint Commission, Standards Manual, *E-dition*, EC 02.02.01.

[49] Acting Assistant Under Secretary for Health for Support (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024.

The OIG explored VHA facilities' patient safety processes. 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 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.[50] 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.[51] 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.

VHA requires facility staff to develop a policy on test result communication and service-level workflows, assigning responsibility to the chief of staff and ADPCS for workflow development.[52] The OIG reviewed the facility policy and several standard operating procedures for service-level workflows, but noted not all services had developed workflows, as required. The Chief of Quality Management told the OIG that staff were not aware the directive required each service to have workflows. The OIG recommends facility leaders ensure staff develop service-level workflows for the communication of test results for each service.

The OIG also noted the facility policy directed staff to report all critical test results to Emergency Department providers outside of normal business hours, which does not align with a VHA directive.[53] The Associate Chief of Staff for Ambulatory Care (primary care) reported having an active role in developing the policy and consulting with the Chief of the Emergency Department for concurrence. The Chief of Staff acknowledged being unaware of the VHA requirement but reported believing their policy was the most appropriate process for communicating critical test results outside of normal business hours, with the Associate Chief of Staff for Ambulatory Care

[50] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[51] Daniel 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.

[52] Service-level workflows describe in writing "the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1).

[53] "The ED [emergency department] must not serve as the default location for off-tour [outside of normal business hours] reporting of new emergent and imminently life-threatening test results without mechanisms to allow notification to the VA medical facility ordering provider or designee." VHA Directive 1088(1).

noting it was an infrequent occurrence. The OIG recommends facility leaders review the test result communication policy to ensure it complies with the VHA requirement for communicating critical test results outside of normal business hours.

Action Plan Implementation and Sustainability

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.[54] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG reviewed patient safety events from the 12 months preceding the inspection and identified a trend involving delayed test result reporting from diagnostic imaging providers to ordering providers. The Chief of Radiology explained they had an agreement with the National Teleradiology Program to provide diagnostic imaging services outside of normal business hours, and its staff caused many of the delays.[55] The chief added they also had a local contract with the University of Louisville and a VISN-contracted service for diagnostic images. The chief provided the OIG with a standard operating procedure for staff to determine where to send diagnostic imaging requests outside of normal business hours and on weekends and holidays.

During interviews, quality management staff reported that both the risk and patient safety manager positions were vacant, since December 2023 and July 2024, respectively, and other staff were covering the roles until they could be filled. However, the Chief of Quality Management mentioned that leaders had selected a candidate for the risk manager position in the spring of 2024, but because of a delayed start date due to VHA staffing budget changes, the person accepted a position outside the facility. The Chief of Quality Management added leaders had selected a candidate for the patient safety manager position, but they were not scheduled to start until November 2024. The OIG remains concerned that having an acting risk manager fill the role over a prolonged period could lead to staff burnout and be a risk to patient safety. However, because leaders were recruiting to fill the position at the time of the inspection in October 2024, the OIG did not make a recommendation.

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

[55] "NTP [National teleradiology program] provides 24/7 diagnostic radiology services to Department of Veterans Affairs (VA) medical facilities located in all Veterans Integrated Service Networks." VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

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.[56] 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.[57] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

VHA policy requires the director to ensure staff review performance metrics for communicating test results and the chief of staff and ADPCS ensure staff take corrective actions to address any noncompliance.[58] The OIG found the FY 2024 performance metrics for timely communication of test results showed a downward trend.[59] Additionally, the OIG reviewed the FY 2024 executive leadership meeting minutes to determine if staff reviewed these metrics and how they reported data and trends to facility leaders. The OIG did not find evidence in the meeting minutes reviewed that staff reported the information to facility leaders, and facility leaders were not able to describe how they learned about the data trends.

The Chief of Staff reported being aware of the performance metrics but could not describe any improvement actions staff had taken, adding that quality management staff are responsible for tracking the metrics. The OIG received documentation from a quality management staff member who described discussing the metrics during monthly meetings with service chiefs, managers, or both, but noted the meetings lacked minutes so the OIG was not able to verify this information. Another quality management staff member shared that service chiefs or managers created workgroups when needed to develop improvement actions. However, the OIG was unable to determine how facility leaders became aware of the downward performance trends and staff did not provide evidence of any improvement action workgroups.

The OIG recommended facility leaders develop a formal process for staff to track performance metrics for test result communication, implement improvement actions, and report compliance to an appropriate oversight committee. The Director responded to the recommendation and reported staff established a formal process to track performance metrics and future monthly reports to a facility committee will include them (see OIG Recommendations and VA Responses).

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

[57] VHA Directive 1050.01(1).

[58] VHA Directive 1088(1).

[59] "All test results requiring action must be communicated by the VA medical facility ordering provider or designee to patients within 7 calendar days from the date on which the results are available to the ordering provider or designee. If a letter is mailed, it must be mailed within 7 calendar days from the date on which the results are available to the ordering provider or designee." VHA Directive 1088(1).

The OIG also interviewed the Acting Patient Safety Manager to determine the adverse event reporting process. The acting manager said the reporting process begins with staff entering the events into the Joint Patient Safety Reporting system, then the patient safety manager reviews the events daily and reports them to facility leaders the next business day. The acting manager added that patient safety staff communicate these events to service chiefs and mid-level managers to develop action plans. The acting manager explained that service chiefs or managers discuss overdue actions with quality management leaders, but there was no formal process to communicate them to executive leaders. Executive leaders should consider creating a formal process for staff to communicate any barriers to completing action plans related to adverse events to them.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[60] 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.[61] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[62] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG reviewed documentation from the Associate Chief of Staff for Ambulatory Care regarding primary care staffing and found four provider, three registered nurse, and three licensed practical nurse positions vacant. The associate chief and Chief Nurse of Primary Care reported the loss of 16 positions over the past FY after VHA's guidance to reduce overall staffing numbers. As a result, the chief nurse and the ADPCS explained they no longer have a nursing float team (staff who are not assigned to a team and cover vacant positions) for primary care, although the associate chief said they still have a number of float providers managing long-

[60] VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[61] 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).

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

term vacancies. As a result of the staffing reduction, the Chief of the Business Office stated five medical support assistant positions were not going to be filled.

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.[63] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[64] The Principal Facility Coordinator for the Patient Centered Management Module confirmed the facility has 40 primary care teams.[65] During interviews, primary care team members stated panel sizes are too large based on their current staffing level. The OIG determined that average panel sizes ranged from 85 percent of VHA's recommended size in October 2022 to 97 percent in October 2024, and 18 of the 40 teams' panels sizes are over 100 percent of the recommended size.

The Associate Chief of Staff for Ambulatory Care said leaders had dissolved two primary care teams over the past year and reassigned the providers from these teams to float positions and the nursing staff and medical support assistants to other teams that had vacancies. The Chief of Staff explained leaders dissolved the two teams because hiring for the positions was no longer approved. The Chief of Staff and the associate chief stated they believed the panel sizes for those teams over 100 percent were also affected by the FY 2024 VISN Director's job performance plan, which included a goal for panel sizes to be 105 percent. The associate chief said by mid-2024, the performance plan was amended and the goal was reduced to 95 percent, but unfortunately this was after leaders had dissolved the two primary care teams, which resulted in some teams' panels being over the recommended size.

A primary care nurse explained when patients from one of the dissolved teams were reassigned to their team, their panel size exceeded 100 percent, causing provider and staff dissatisfaction. To help lessen the providers' burden, primary care team members stated that pharmacy staff managed the medications for patients with chronic conditions, which helped to reduce provider appointments. Additionally, the associate chief acknowledged that when panel size is high, patient access and satisfaction decreases, and staff burnout increases.

The Chief of Staff stated efforts to reduce panel size to expected numbers were ongoing, and replacing the two dissolved primary care teams would help. The chief added that executive leaders should approve hiring for the two primary care teams within 30 days of the OIG's inspection in October 2024. The ADPCS noted that facility leaders meet almost weekly to

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

[64] VHA Directive 1406(2).

[65] "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." VHA Directive 1406(2).

discuss and prioritize positions for approval. The Chief of Staff explained, however, that it is difficult to hire qualified and experienced primary care physicians due to national shortages and local competition, and leaders need to hire nurse practitioners and physician assistants to fill these roles.[66] The Associate Chief of Staff for Ambulatory Care further described a preference for physicians to have internal medicine or family practice experience, and nurse practitioners and physician assistants to have a strong primary care background and several years' experience, which added to the hiring challenge.

The OIG reviewed wait time data and found that new patient appointment wait times had gradually increased from 12 days in FY 2023, quarter one, to 28 days in FY 2024, quarter three. The associate chief reported reviewing wait time data several times per month and stated staff are attempting to schedule appointments sooner for new patients waiting longer than 20 days.

Because larger panels and staffing vacancies are increasing staff workload, appointment wait times, and dissatisfaction among staff and patients, the OIG recommended facility leaders manage panel sizes to ensure patients have timely access to high-quality care. The Director responded to the recommendation and reported leaders added 2.5 primary care teams and reduced panel sizes from 100.7 percent to 95.6 percent full (see OIG Recommendations and VA Responses).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[67] 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 reported they have brief daily team meetings and immediate supervisors are supportive and responsive to their concerns. The Associate Chief of Staff for Ambulatory Care explained how leaders also use quality metrics and All Employee Survey data to identify areas for improvement. For instance, based on survey comments, leaders developed a new process that decreased the number of electronic alerts providers received for consults by only sending an alert when the consults are closed or canceled.[68]

The Associate Chief of Staff for Ambulatory Care acknowledged the biggest challenge for primary care staff is workload; it is not related solely to the number of assigned patients, but also

[66] 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).

[67] VHA Handbook 1101.10(2).

[68] Alerts are computerized "auditory or visual warnings to clinicians to prevent or act on unsafe situations." "Alert Fatigue," "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

the volume of patient information teams are required to review, including laboratory and radiology results and community care records. The staff also discussed challenges they faced during a typical day, including patients who arrived late or without an appointment. This resulted in less time for staff to spend with scheduled patients, lowered patient satisfaction, and added to staff workload.

A provider expressed frustration and described challenges with the time-consuming process for specialty consultations, including completing required additional testing before a VA specialist would accept a patient. The provider further explained that consults expire every six months and when patients need specialty care beyond that time frame, providers have to re-enter them into the electronic health record. Several times during the interview, the provider indicated they did not mind doing the work but felt they did not have sufficient time to complete all necessary tasks. The provider reported sharing these frustrations at monthly provider meetings and acknowledged receiving two hours per week of administrative time after a recent change, allowing them to catch up on paperwork. The associate chief stated they were working with specialty services to improve processes and collaboration.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. During interviews, primary care staff said implementation of the PACT Act had minimal impact on their day-to-day functions.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice 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.[69]

[69] 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).[70] 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."[71]

The HCHV program was exempt from reporting the HCHV5 metric through FY 2023.[72] Instead, an HCHV staff member said they used other performance measures and the VHA Homeless Programs Office annual report to evaluate their success. The OIG reviewed documents submitted by facility staff showing the program had five staff members who performed outreach daily to provide veterans with an intake assessment, which enrolls them into the homeless program, and grants access to available services in their location. The Section Chief for Homeless Programs shared the team collaborates with community case managers and ensures veterans are connected with the right people and receive help to obtain whatever documents they need to receive services. The team's successes are measured through their interactions and ability to assist the veterans with available services in the area.

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

[71] 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.

[72] Starting in FY 2016, VHA granted a waiver to facilities from the HCHV5 performance measure if there were not enough unsheltered veterans to meet the target. VHA Homeless Programs, *HCHV5: Engagement of Unsheltered Veterans–FY23 Exempted Sites*.

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).[73]

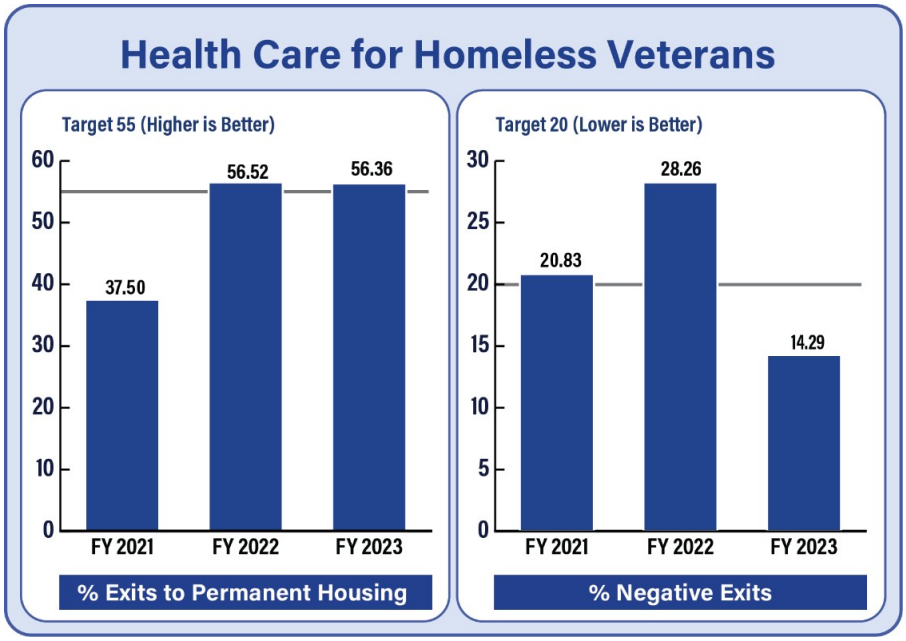

Figure 9. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program did not meet the HCHV1 target in FY 2021, but did in FYs 2022 and 2023. Staff attributed the program's improvement to effective case management in which they connect veterans to healthcare and community partners that help with needs, such as rental subsidies or housing. Staff also assess veterans to identify necessary support. Staff noted they face challenges finding options for aging veterans, who often require additional support.

The program did not meet the HCHV2 target in FYs 2021 or 2022 but did in FY 2023. The Section Chief for the Homeless Programs explained that case management, as well as preparing veterans for permanent housing, helped to reduce their negative exits.

Further, a staff member said their government-furnished car was unequipped to transport a motorized wheelchair, so they accompanied a veteran needing healthcare to a bus stop to catch a bus to the facility. VHA requires the homeless program coordinator to collaborate "with the VA medical facility Director to ensure that HCHV Outreach Services staff are provided with

[73] 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*.

sufficient government-furnished equipment to conduct day-to-day outreach services safely and effectively."[74] However, since VHA does not specify that program staff must have government-furnished vehicles to transport veterans who require wheelchairs, the Homeless Program Coordinator should evaluate the type of vehicle needed and discuss the concern with leaders.

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."[75] 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.[76]

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).[77] A program staff member explained they did not meet target for FYs 2022 and 2023 due in part to being assigned more vouchers than needed for the number of homeless veterans in the area. A program staff member said their efforts included continuing to look for affordable housing and exploring other creative options such as housing veterans together.

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).[78] The facility's program exceeded the VASH3 target consistently from FYs 2021 through 2023. The program lead attributed this to a team of 21 dedicated staff who worked collaboratively to create a unified outreach approach, which includes weekly meetings with community partners

[74] VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

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

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

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

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

and HCHV staff to share updates. Additionally, a program staff member indicated that community partners helped remove barriers to veterans obtaining housing by providing financial assistance and support such as application fees, deposits, and household items. A staff member also reported tracking outreach efforts and noted that case management services included assistance with appointment scheduling and transportation.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[79] 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.[80]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[81] The facility's program exceeded the target in FY 2023. The Veterans Justice Program Lead stated they have three employees who collaborate with legal clinics, jail staff, attorneys, and court liaisons to identify veterans who may be eligible for the program. Program staff explained they have formal agreements with all the treatment courts in their service area to provide eligible veterans with health care services, such as treatment for substance use and mental health concerns, while going through the legal process.[82] They did not identify any barriers to determining eligibility or enrolling veterans in the program.

Meeting Veteran Needs

A program staff member stated their objectives included linking enrolled veterans to programs and services for healthcare treatment, housing, and employment. Staff coordinate veteran care through referrals from facility services, such as mental health and other homeless programs. Additionally, program staff manage veterans' care based on individual needs and refer those who are not eligible for VA health care to community partners. Lastly, a staff member explained

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

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

[81] 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*.

[82] "A Veterans Treatment Court is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

veterans graduated the program after they completed treatment court requirements, or were discharged if they decided to terminate their participation with the court.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to telephone system vulnerabilities; exit signs; walkway, electrical cord, biohazardous material, and liquid nitrogen safety; cleanliness; test result communication; and primary care panel sizes. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Responses). 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.

OIG Recommendations and VA Responses

Recommendation 1

The Executive Director oversees improvements to the telephone system to ensure identified vulnerabilities are addressed.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

The Executive Director reviewed this recommendation and identified no further reasons for non-compliance. A dedicated workgroup has been established to address phone service issues. The workgroup discovered that the facility had multiple phone numbers: one for the main hospital, eight for each Community Based Outpatient Clinic (CBOC), and several other direct lines to various clinics. Collaborating with the Office of Information Technology department, they streamlined the system by reducing the numbers to a single centralized toll-free number.

Additionally, the script providing options to Veterans when calling was significantly condensed from nine pages and 2500 words to three pages and 800 words, enhancing both speed and efficiency. The previous system had 11 separate areas handling phone calls, which has now been consolidated into one direct line. Furthermore, five specialty areas previously had phone numbers directing calls to potentially unattended desks. These lines have been integrated into a specialized call system branching from the main toll-free number. This new system allows for tracking and trending of call abandonment rates and response times, which were previously unavailable for these clinics.

As a result, the call abandonment rate for the primary registered nurse call center decreased from an average of 33% in October 2024 to 20% in August 2025. The workgroup continues to implement improvements and increase staffing. Their goal is to maintain an abandonment rate of less than 10% for at least six months, with results reported to the Quality Patient Safety Committee (QPSC).

Recommendation 2

Facility leaders ensure exit signs lead to an exit.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

To ensure compliance with 29 C.F.R.§1910.37, maintenance, safeguards, and operational features for exit routes, a thorough evaluation of all exit signs within the facility will be conducted and completed by September 30, 2025. During this assessment, any exit signs that are found to be noncompliant, damaged, or unclear in directing staff, Veterans, or visitors will be repaired, replaced, repositioned, or removed as necessary.

To maintain ongoing compliance, exit sign inspections will be incorporated into the weekly Environmental Care rounds (EOC) checklist. Any instances of non-compliant signage will be promptly addressed and documented, progress reports presented at the monthly Comprehensive Environment of Care Committee (CEOC) meetings. Compliance of >90% will be reported for at least six months. Compliance will be measured by the number of areas with correct signage (numerator) over the total number of required exit signs in the surveyed areas (denominator).

Recommendation 3

Facility leaders install detectable warning surfaces anywhere a walkway transitions into a roadway.

_X_ Concur

____ Nonconcur

Target date for completion: November 30, 2025

Director Comments

Facility leaders will ensure detectable warning surfaces are installed at all walkways to roadway transition points in accordance with the OIG recommendation.

The facility will conduct an audit of all walkways by September 30, 2025, and correct deficiencies by installing warning surfaces in appropriate areas by November 30, 2025. The results will be reported to the CEOC at completion to demonstrate 100% compliance with all transition points.

Recommendation 4

The Executive Director ensures staff keep patient care areas clean and safe.

_X_ Concur

____ Nonconcur

Target date for completion: February 15, 2026

Director Comments

The Associate Director of Operations evaluated and determined no additional reasons for noncompliance. The Environmental Management Service (EMS) Supervisory staff will conduct Quality Assurance inspections with a minimum of one patient care area per month. Inspections will focus on identification of dust and dirt on bed frames beneath the mattresses on examination tables. Findings will be remediated at the time of inspection. A minimum of 90 % EMS compliance will be achieved for six consecutive months. EMS will report data to the CEOC.

The Engineering Department has contracted a fire sprinkler inspector to conduct sprinkler head dusting; initial cleaning was performed in August 2025 and will continue annually for the Robley Rex Department of Veterans Affairs Medical Center (RRVAMC). The unserviceable furniture identified was replaced and the electrical cords found connected to unsecured power strips were removed promptly throughout RRVAMC. In March 2025 education for engineering staff was provided for electrical cord power strips to safeguard inappropriate usage. A risk assessment was completed for electrical cord management September 3, 2025, please see recommendation five. Electrical cord power strips, torn furniture, and surveillance of ice machines have been included in environmental care rounds and are reported to the CEOC. Compliance Monitor: The numerator is the number of inspections where patient care areas were compliant with electrical cord management, free from torn furniture and clean ice machines. The denominator is the total number of areas inspected. Compliance Goal: 90 percent or greater for a minimum of six consecutive months.

Recommendation 5

Facility leaders ensure staff conduct a risk assessment for electrical cord management to identify and implement any needed improvements.

_X_ Concur

____ Nonconcur

Target date for completion: November 30, 2025

Director Comments

Following a comprehensive risk assessment concerning electrical cord management at RRVAMC, found that the likelihood of hazards related to electrical cords is classified as low to low-medium risk. The specific issue concerning electrical cord(s) in the previously identified areas have been rectified. To ensure ongoing safety and effective management, the following procedures have been implemented: Maintenance personnel will inspect electrical cords during their use, weekly inspections will be conducted during Environmental Care (EOC) rounds, and electrical cords in high-traffic areas will be checked to prevent any potential hazards. The risk

assessment will be submitted to the CEOC in October of 2025 for approval and closure of this recommendation will be requested in November 2025.

Recommendation 6

The Executive Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present and store clean and dirty items separately.

_X_ Concur

____ Nonconcur

Target date for completion: April 30, 2026

Director Comments

The Associate Director for Resources has ensured the biological hazard signs are posted on all doors rather than adjacent to the door. This action of relocating the signage was completed by July 7, 2025, except for inpatient mental health as special-order non-ligature signage had to be ordered. The station is expecting delivery of the remaining signage by October 1, 2025. Expected completion by October 30, 2025, with the installation of all signage. The items identified as clean and dirty were removed and separated during inspections. Monthly inspections are conducted in patient care areas to assess clean and dirty equipment being stored separately. In addition, EOC rounds are completed per Directive; In the event soiled equipment is found, it would be immediately removed, and managers are notified. Compliance Monitor: The numerator is the number of inspections where patient care areas were compliant with clean and dirty equipment being stored separately. The denominator is the total number of areas inspected. Compliance Goal: 90 percent or greater for a minimum of six consecutive months. Compliance will be reported to the CEOC.

Recommendation 7

The Executive Director ensures prompt disposal of biohazardous waste.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

The Associate Director for Resources has identified that there was a change in contracts that caused a delay with picking up the biohazardous waste at the CBOCs. A new contract was awarded, August 26, 2025, and scheduled pickups have been executed. All emergency waste has been disposed of with frequency of pickups varying by clinic need but no less than monthly. We

will ensure biohazardous waste is removed from all facilities 100% of the time monthly. Primary care will perform an audit of their biohazardous rooms pick up status and compliance of 100% will be reported monthly to the CEOC until 100% compliance has been reported for six consecutive months.

Recommendation 8

Facility leaders ensure staff conduct a risk assessment on liquid nitrogen use and storage, to include devices in exam rooms, and implement changes accordingly.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

After conducting a thorough evaluation, RRVAMC has found that the likelihood of hazards is low to low-medium risk. Per this risk assessment our current management procedures adequately control the risk and there is no significant danger. The alarm in the room indicated on the finding has been repaired and is now functional. Staff who use liquid nitrogen will be educated not to leave the unattended devices in rooms and rooms will be audited by managers in the area. Audits will be performed weekly and reported to the CEOC until 90% compliance has been reported for six consecutive months.

Recommendation 9

The Executive Director ensures the Comprehensive Environment of Care Committee identifies at least one facility-specific environment of care trend and establishes a performance improvement plan, including outcome measures, to address it.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2026

Director Comments

The Associate Director for Resources evaluated this recommendation and found no additional reasons for noncompliance. The current CEOC charter has been reviewed and reflects compliance with VHA Directive 1608(1) Comprehensive Environment of Care Program. The CEOC committee is a multidisciplinary group that will review the most reported issues identified in the weekly environment of care rounds. A continuous performance improvement plan, including outcome measures, will be a standing agenda item for the committee. To improve trend

analysis, a reduction in categorizing deficiencies as miscellaneous has been identified as the performance improvement plan for this and an outcome measure has been established. Compliance will be met after six (6) consecutive months of minutes of the CEOC to show discussion of environmental of care trends and the progress of performance improvement as a standing agenda item.

Recommendation 10

Facility leaders ensure staff develop service-level workflows for the communication of test results for each service.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

RRVAMC will develop workflows for communication of test results for each service in compliance with VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023. The Chief of Staff is responsible for this action. The Chief of Staff ensures the service-level workflow for test results communication includes service and standard timeframes for high-risk patients consistent with RRVAMC requirements via service level Standard operating procedure Audits will be performed to ensure all services include workflows. 100% of all clinical areas will be included in the audit by September 30, 2025. Compliance with this item will be monitored and reported to the HDC committee monthly until 100% compliance has been reported for six consecutive months. Monitoring for compliance of timely communication of test results will be performed and reported in recommendation 12.

Recommendation 11

Facility leaders review the test result communication policy to ensure it complies with the VHA requirement for communicating critical results outside of normal business hours.

_X_ Concur

____ Nonconcur

Target date for completion: April 30, 2026

Director Comments

RRVAMC meets the required timeframe for notifying providers of critical results. However, during weekends, holidays, evenings, and nights (WHEN), notifications are being sent to the Emergency Department, which the directive prohibits. To address this, RRVAMC is evaluating

three potential alternatives for managing these results: the Veterans Integrated Services Network (VISN) wide call center of advanced practice nurse practitioners (APRN)s and physician assistants (PA)s, a dedicated overnight on-call team (medicine/hospitalist), or Service-Based rotations. All potential avenues have some challenges. The VISN Wide Call Center is not under the direct control of RRVAMC. There is not 24-hour coverage by Providers of the VISN Wide Call Center. The dedicated overnight team may require more staffing and infrastructure changes, and the physician groups identified as options are often commuting home from their day when these calls are most likely to occur which could impact timeliness of access to the patient record and notification of the veteran. Ensuring that all providers within the Service-Based rotation system understand their responsibilities and are accountable for managing critical test results can be challenging, particularly during transitions and handoffs between shifts. Each of these options presents its own set of challenges that must be addressed to provide effective and timely coverage for overnight critical results reporting.

Our current system is safe and meets the timelines established, with the intent of the Directive. Our current system has 30 calls per month to the Emergency Department. Considering the operational impact, RRVAMC requests a six-months timeframe to allow a safe and sustainable transition, with a target date for completion by February 2026. Once finalized, the Standard Operating Procedure will be updated and reviewed for concurrence with stakeholders for compliance with the Directive. Upon initiation of the new process, the Chief of Quality will audit compliance with the Directive for timely notification of critical test results and notification through the determined party. This audit will cover 100% of WHEN hour critical test results per month over six consecutive months, aiming for 90% compliance and report results to the HDC monthly until 90% compliance is reported for six consecutive months.

Recommendation 12

Facility leaders develop a formal process for staff to track performance metrics for test result communication, implement improvement actions, and report compliance to an appropriate oversight committee.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

To address these recommendations, the facility has established a formal process to track performance metrics related to the communication of test results. Metrics related to communication of test results will be included in the monthly HDC reports and will identify downward trends and include actions when needed. Compliance will be met with reporting of

critical value trends and any subsequent actions to the HDC board monthly. Compliance will be monitored for six consecutive months of 90% or greater.

Recommendation 13

Facility leaders manage panel sizes to ensure patients have timely access to high-quality care.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

The Associate Chief of Staff for Primary Care reviewed the existing processes and obtained feedback from ambulatory care staff in identifying areas for improvement. Primary care has added 2.5 Patient Aligned Care Team (PACT) Teams since October 2024 bringing the total number of PACT teams from 40 to 42.5 teams. They are restricted from adding additional PACT teams due to space constraints and hiring restrictions. They have reduced panel fullness from 100.7% to 95.6% while simultaneously increasing overall active patients in the system by >1000 patients. They have been following the PACT roadmap and requesting additional resources as directed in the guide. They will maintain the current number of PACT teams moving forward at 42.5 or greater and maintain PACT fullness percentage of at least 96% and will report to HDC committee until a minimum of 96% has been reported for six consecutive months.

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, and relevant prior OIG and accreditation survey reports.[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.[2] 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.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from October 1 through 3, 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 and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

[2] The OIG sent surveys to multiple VSO representatives provided by the VA Louisville Healthcare System staff but received a response from only one VSO.

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

[4] 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.[5] 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.

[5] 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
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.
	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.

Category	Metric	Metric Definition
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 in this report were coded according to International Classification of 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.
	< 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.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

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.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES 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.

Category	Metric	Metric Definition
	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 graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: Additional Facility Photographs

Figure C.1. *Limited visibility of exterior navigational signs.*
Source: Photo taken by OIG inspector.

Figure C.2. *Photo of drive-up ramp to clinic entrance.*
Source: Photo taken by OIG inspector.

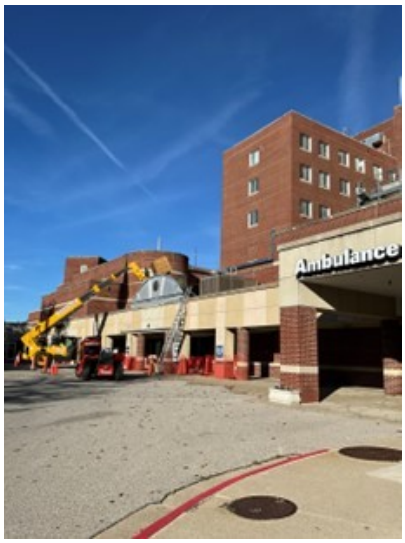

Figure C.3. *Unattended construction site at clinic entrance.*
Source: Photo taken by OIG inspector.

Figure C.4. *Unattended ladder at clinic entrance.*
Source: Photo taken by OIG inspector.

Figure C.5. *Unattended ladder at clinic entrance.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2025

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky

To: Director, Office of Healthcare Inspections (54HF03)

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky. I concur with the action plans submitted.
2. We thank the OIG for the opportunity to review and respond to the Draft Report: Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky.

(Original signed by:)

Anthony M. Stazzone, MD, MBA, FACP
Acting Network Director, VISN 9

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 4, 2025

From: Director, VA Louisville Healthcare System (603)

Subj: Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky

To: Director, VA MidSouth Healthcare Network (10N9)

1. Attached please find the Louisville VA Medical Center's response to the OIG Draft Report, Healthcare Facility Inspection of the Louisville Healthcare system in Kentucky.
2. If there are any further questions regarding this response, please contact Quality and Patient Safety, Robley Rex VA Medical Center.

(Original signed by:)

Jo-Ann Ginsberg, RN, MSN
Executive Director

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.