US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Durham VA Health Care System in North Carolina

Healthcare Facility Inspection	24-00586-11	December 11, 2024

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established a cyclical review program called Healthcare Facility Inspection. 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 Durham VA Health Care System during the week of February 26, 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 (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. Employees identified system shocks as executive leadership turnover and the aging infrastructure, which leads to recurring electrical outages, phone system failures, and water leaks that disrupt patient care and work productivity. Leaders work with the Veterans Integrated Service Network contracting office to quickly respond to emergency maintenance and construction issues.[2]

Based on responses to the OIG's questionnaire regarding leadership communication, employees praised the Director's high level of engagement and generally had positive perceptions of their work environment. However, some employees had concerns about the leaders' communication methods. Although leaders share information in a variety of ways, some employees said the information is not timely, and the high volume makes it difficult to decide what is essential.

[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.

[2] Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Services Networks (VISNs)," Veterans Health Administration, accessed June 5, 2024, https://www.va.gov/HEALTH/visns.asp.

Regarding veterans' experiences, leaders expressed concern about the rapid growth of the veteran population. They explained that many veterans live in rural areas that do not have a local VA facility nor many community care options.[3] Therefore, executive leaders work closely with county commissioners and other federal agencies to lease underused government space to establish VA care in these locations.

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

The OIG noted the parking and entrances were easily accessible. However, the OIG found a potential safety hazard for veterans accessing one of the parking garages due to the lack of a formal crossing zone. Additionally, facility maps and directories were not up to date, and the informational pamphlets provided to veterans at the entrances showed an exterior view of the facility but no directions to clinic locations. The OIG also found the facility lacked adequate design features to assist veterans with sensory impairments, such as sign language interpretation services, and patient escorts had not been trained on how to communicate with sensory-impaired veterans. The OIG made recommendations to address these issues.

The OIG found no substantial evidence the facility had a process for staff to thoroughly examine environment of care deficiencies for trends, which the Associate Director acknowledged. The OIG also discovered unsecured high-alert medications in the Emergency Department, supply rooms with expired medical supplies and dusty shelves in multiple units, and worn and peeling signage throughout the facility. The OIG made recommendations to resolve these vulnerabilities.[4]

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 findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found that diagnostic and laboratory leaders had

[3] "VA provides care to Veterans through community providers when VA cannot provide the care needed" "Community Care," Department of Veterans Affairs, accessed April 11, 2024, https://www.va.gov/communitycare/.

[4] "A high-alert medication is a drug that bears a heightened risk of causing significant adverse events that cause harm to a patient." VHA Directive 1310(1), *Medical Management of Enrolled Veterans Receiving Self-Directed Care From External Health Care Providers*, October 4, 2021, amended April 13, 2022.

policies for notifying providers and patients of critical test results and tracking communications. However, the Associate Chief of Staff, Ambulatory Care Service reported challenges with laboratory or radiology staff communicating abnormal results to ordering providers from community-based outpatient clinics or after clinic hours.

During interviews, leaders said service chiefs monitor providers' communication of results to patients based on the number of unaddressed view alerts (notifications in electronic health records). However, the OIG found that leaders did not have a process for quality management staff to validate service chiefs' processes for monitoring providers' compliance with communicating abnormal test results to patients. The OIG also identified delays in communication and follow-up of abnormal test results to patients across multiple clinical areas, as evidenced by adverse patient safety events, including four events that had institutional disclosures.[5] In addition, staff did not consistently enter adverse patient safety events into the Joint Patient Safety Reporting system or monitor trends to identify recurring issues.[6] The OIG made recommendations for leaders to improve processes to ensure patient safety.

Primary Care

The OIG examined whether primary care teams were staffed per VHA guidelines and received support from facility leaders. The OIG also assessed how Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[7] The OIG found the implementation of the PACT Act and current staff vacancies had no significant impact on primary care team workflows or patient access.

According to primary care leaders, vacancies (10 primary care provider, 7 registered nurse, 14 licensed practical nurse, and 7 medical support associate positions) were mostly due to employee retirements and losses to non-VA hospitals because of lower VA salaries and the lack of flexible work schedules. Executive leaders approved various recruitment and retention incentives to improve staffing, such as pay increases and student loan repayment. Despite the vacancies, the OIG found no significant issues with primary care team workflows. Further, new patient

[5] An institutional disclosure "is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[6] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

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

appointment wait times were less than 20 days from fiscal years 2023 and 2024 through February 2024.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans outreach coordinators collaborated with community partners to host a yearly outreach event called Stand Down. During the event, staff enroll veterans into the Health Care for Homeless Veterans program or refer them for other VA resources, and veterans can receive food, clothing, health care, and legal aid. However, staff said veterans' lack of available personal information, such as social security numbers and military discharge papers, could delay enrollment.

The outreach coordinators also reported the facility had used funding from the Coronavirus Aid, Relief, and Economic Security Act of 2020 to provide temporary lodging for homeless veterans and other resources to help them secure permanent housing.[8] However, the pandemic funding has ended, housing costs have increased significantly, and many property managers stopped accepting housing vouchers or sold their properties, which has limited affordable housing options for veterans. Therefore, program staff are identifying other public housing authorities to expand housing options for veterans and planning an engagement event to encourage landlords to participate in the program.

What the OIG Recommended

The OIG made 11 recommendations.

1. Executive leaders ensure staff store all high-alert medications in a secure or locked area.
2. Executive leaders ensure staff follow their processes to prevent the storage of expired medical supplies and that supply areas remain clean.
3. Executive leaders ensure staff keep the facility free of temporary signage that may interfere with cleaning and disinfection processes.

[8] Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136, 134 Stat. 281 (2020). The Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020) was "signed into law on March 27, 2020," and "provided fast and direct economic assistance for" Americans "to address issues related to the onset of the COVID-19 pandemic." "About the CARES Act and the Consolidated Appropriations Act," Department of Treasury, accessed March 20, 2024, https://home.treasury.gov/policy-issues/coronavirus/about-the-cares-act.

4. The patient safety manager confirms staff enter known patient safety events into the Joint Patient Safety Reporting system for use in the initial assessment of these events.
5. Executive leaders ensure quality management staff implement an oversight process to validate providers' compliance with patient communication and follow-up for urgent, noncritical abnormal test results.
6. Executive leaders evaluate options to improve safety at the informal crossing area near parking garage B.
7. Executive leaders ensure all directories are accurate and provide specific details so veterans can easily navigate the facility.
8. Executive leaders implement additional features to aid veterans with sensory impairments to navigate the facility.
9. Executive leaders ensure staff train patient escorts on how to effectively communicate with sensory-impaired veterans.
10. Executive leaders ensure the Comprehensive Environment of Care Committee reviews environment of care deficiencies for trends and opportunities for improvement.
11. Executive leaders ensure staff review patient safety events for trends and system vulnerabilities and implement process improvement actions to prevent future occurrences.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Executive Director concurred with recommendations 1–9, concurred in principle with recommendations 10 and 11, and provided acceptable improvement plans (see appendixes C, D, and E for the full text of the directors' comments). Based on the information provided, the OIG considers recommendations 3, 4, and 6 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Abbreviations

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	veteran service organization

FACILITY IN CONTEXT

Durham VA Health Care System
Durham, North Carolina
Level 1a-High Complexity Facility
Durham County
Hospital Referral Region: Durham

Description of Community

RACE AND ETHNICITY

- White 56%
- Black 24%
- Two+ 7%
- Other 6%
- Asian 4%
- Native 2%
- Islander 0%

MEDIAN INCOME

$49,142

EDUCATION

84% Completed High School
58% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **226**

POPULATION

Female **2,156,288**
Male **2,023,292**
Veteran Female **38,857**
Veteran Male **227,214**

Homeless—State **9,382**
Homeless Veteran—State **687**

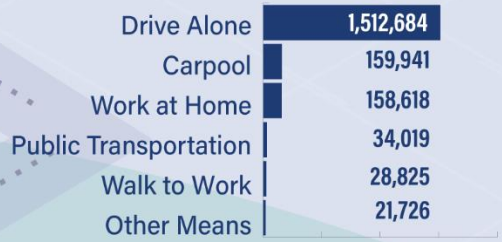
UNEMPLOYMENT RATE

5% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Work Force

SUBSTANCE USE

28.2% Driving Deaths Involving Alcohol
16.8% Excessive Drinking
1,493 Drug Overdose Deaths

TRANSPORTATION



Drive Alone	1,512,684
Carpool	159,941
Work at Home	158,618
Public Transportation	34,019
Walk to Work	28,825
Other Means	21,726

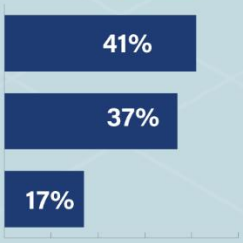
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**33 Minutes, 26.5 Miles**
Specialty Care	**47.5 Minutes, 43 Miles**
Tertiary Care	**80 Minutes, 73 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **27,320**



Veterans Receiving Teleheath (VHA)	41%
Veterans Receiving Telehealth (Facility)	37%
<65 without Health Insurance	17%

Health of the Veteran Population

VETERAN RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

23,111

272 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.56 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
17	29

Health of the Facility

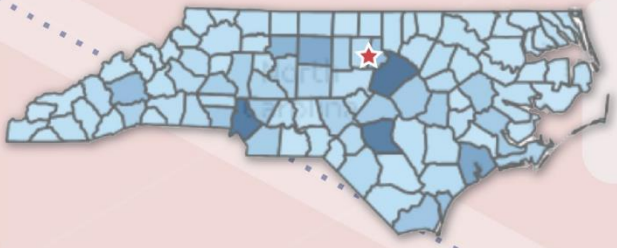
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	86K
Unique Patients VA Care	82K
Unique Patients Non-VA Care	35K

COMMUNITY CARE COSTS

Unique Patient	Line Item	Bed Day of Care	Outpatient Visit
$22,490	$422	$288	$415

CLASSIFICATION



★ VA MEDICAL CENTER

VETERAN POPULATION

230 — 54,125

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.01%
Facility Total Loss Rate	12.80%
Facility Retire Rate	2.37%
Facility Quit Rate	9.44%
Facility Termination Rate	0.86%

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

Contents

Background and Vision

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

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

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

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about

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

the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

High Reliability Organization Framework

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

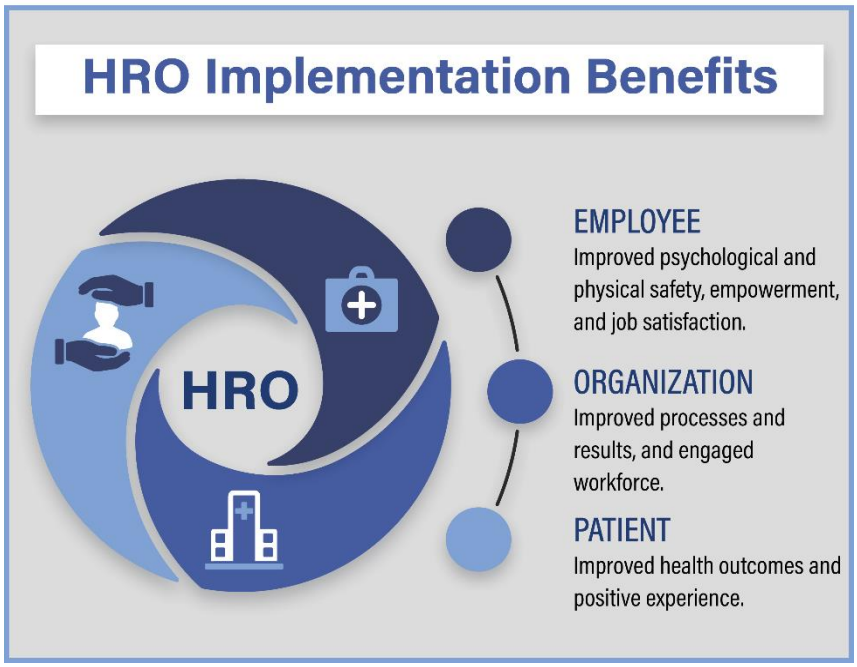


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

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

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

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

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

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

The Durham VA Health Care System (facility) is a level 1a complexity, affiliated teaching and research hospital that opened in April 1953.[13] At the time of the inspection, the facility had an executive team consisting of a Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Service, Associate Director, Assistant Director, Assistant Director for Experience, Deputy Chief of Staff, and Interim Deputy Associate Director for Patient Care Service. The Director joined the executive team in May 2022, and the newest executive team member, the Deputy Chief of Staff, started in January 2024. In fiscal year (FY) 2023, the facility's budget was approximately $1.1 billion. The facility has 151 hospital beds and 100 approved community living center beds serving more than 80,000 enrolled veterans.[14]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, workplace diversity, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VHA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

[13] VHA medical facilities are classified according to a complexity model; a designation of "1a" indicates a facility with "high volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "Facility Complexity Level Model Fact Sheet," October 1, 2017. "An academic affiliate is an educational institution" that fosters education and training through a relationship with a VA medical facility. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 10, 2024, https://www.va.gov/GERIATRICS/CLC/VA.asp.

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

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19] 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.

In an OIG-administered questionnaire, respondents identified turnover in key leadership positions as one example of a system shock. During an interview, the Director expressed understanding how any healthcare system change, like leadership turnover, can affect staff. To minimize potential adverse effects due to organizational change, the Director discussed evaluating the current state of the healthcare system before implementing new processes or ideas and communicating to staff the reason for the change. The Director also stressed empowering staff to speak up and share process improvement ideas and to address issues quickly and effectively as they arise. The OIG noted this aligns with the principles of an HRO that encourage active communication between staff and leaders to address safety and quality concerns.

The executive leaders reported that the main facility's aging infrastructure is another system shock, resulting in recurring electrical outages, phone system failures, and water leaks that disrupted patient care and work productivity. The Associate Director reported having a good relationship with the Veterans Integrated Service Network (VISN) contracting office, which allows leaders to respond to emergency maintenance, repair, and construction issues quickly when needed.[20]

Based on executive leader interviews and questionnaire responses, the OIG concluded that leaders appear to be aware of system shocks affecting staff and are taking steps to minimize the impact. The OIG made no recommendations.

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

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

[20] Veterans Integrated Service Networks (VISNs) are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Services Networks (VISNs)," Veterans Health Administration, accessed June 5, 2024, https://www.va.gov/HEALTH/visns.asp.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] 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.[22] 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."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]

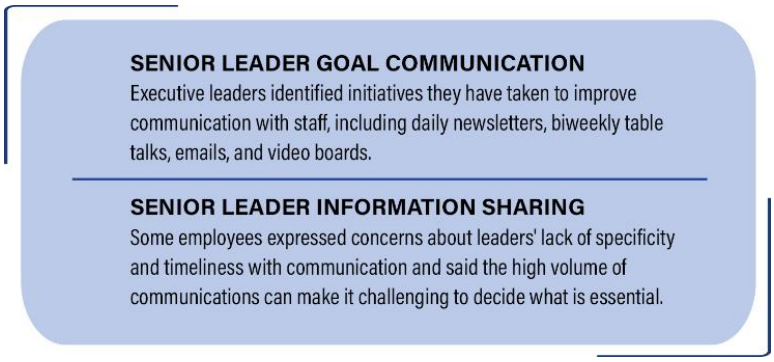


Figure 4. *Leader communication with staff.*
Source: OIG analysis of survey data and interviews with facility leaders.

The OIG also administered a staff questionnaire and results revealed that they praised the Director's high level of engagement. In a panel interview with executive leaders, the Director described the following strategies to improve communication with frontline staff: visiting facility and community-based outpatient clinic staff working different shifts, including nights and weekends, and hosting recorded virtual meetings. The Associate Director of Patient Care Services added that executive team members visit different departments weekly to allow staff time to discuss concerns with them directly.

Although most staff responded positively in the OIG questionnaire about how facility leaders communicate, some expressed concerns about leaders' lack of specificity and timeliness and the high volume of communications. Staff also indicated they wanted leaders to improve how they share information and follow up on outstanding questions or concerns. In an interview, executive leaders said communication with staff occurs through several channels: the Durham Daily (an

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

[22] 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*.

[23] 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.

[24] 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.

email newsletter created based on staff feedback to consolidate communication efforts), bi-weekly table talks (meetings where subject matter experts share information with staff), emails, and video boards. The Associate Director added that using technology, such as Facebook live events, instant messaging, and a Gratitude app, has improved communication with staff.[25]

Although OIG questionnaire responses indicated some staff have concerns about executive leaders' communication methods, the OIG found leaders streamlined communication to address the concerns and shared information in a variety of ways. The OIG made no recommendations.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[26] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[27] Organizations with cultures that celebrate diversity and inclusion encourage self-expression and enhance psychological safety, part of the safety culture, which is foundational to an HRO.[28] Having workplace staff representative of the veterans and surrounding community can build trust, facilitate communication, and strengthen the relationship between the facility and veterans served.[29]

[25] The Associate Director explained that the National Program Office created the Gratitude app, a VA internal web-based application, as a tool for employees to show appreciation for the actions of other employees. The Associate Director said facility leaders made recommendations for improvements to the app to include the ability to thank others for speaking up and making a difference.

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

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

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

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

The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity. The 2023 VA survey data for discrimination, authenticity, inclusivity, opportunity, and workplace diversity improved from the previous two years. The OIG found that in FY 2023, the percentage of veteran staff at the facility declined throughout the year, while staff identifying as having a targeted disability increased slightly. The Director attributed the decline in veteran staff to temporary exclusions in veterans' preference for an expanded list of occupations.[30]

Figure 5. *Facility workforce diversity.*
Source: OIG analysis of facility human resources data.

The OIG reviewed the facility's staffing data and Equal Employment Opportunity program status report and noted the facility's racial workgroup representation was generally comparable to the civilian labor force. The Chief of Staff reported that executive leaders focused on diversity and equity in the last few years by identifying staff champions to assist other staff regarding diversity concerns. Furthermore, leaders explained that they provide unconscious bias training to staff to ensure unbiased hiring practices.[31] Additionally, the leaders described developing relationships with nearby Historically Black Colleges and Universities to aid in recruiting a more diverse workforce. The OIG made no recommendations.

[30] Veterans' preference is employment preference given to eligible veterans meeting certain active duty criteria or have a service-connected disability. "Veterans' Preference," Office of Personnel Management (OPM), accessed July 25, 2024, https://www.opm.gov/fedshirevets/current-veteran-employees/veterans-preference/.

[31] "Unconscious biases (also known as implicit biases) are involuntary stereotypes or attitudes held about certain groups of people that may influence [their] behaviors, understandings, and actions, often with unintended detrimental consequences." Temitayo A. Ogunleye, "Unconscious Bias," *Dermatologic Clinics* 41, no. 2 (April 1, 2023): 285-90, https://www.clinicalkey.com.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[32] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[33] 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.

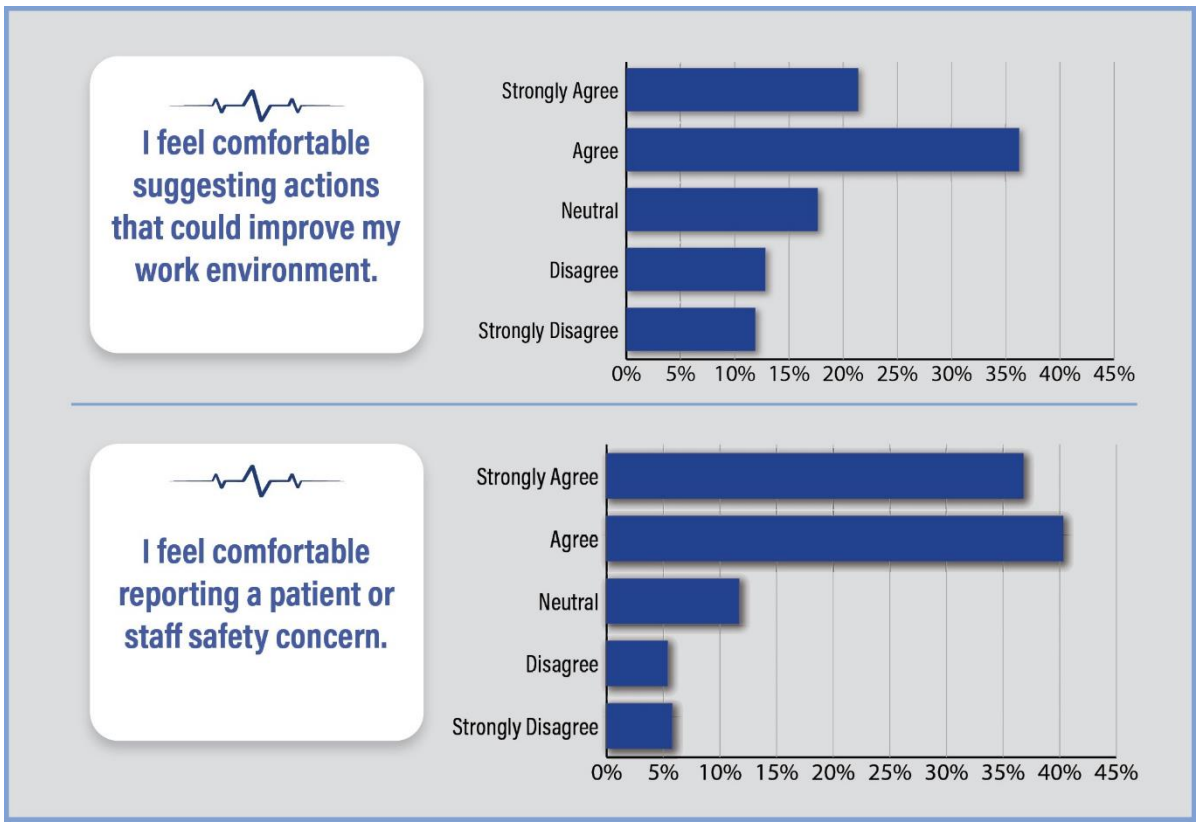


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: Analysis of OIG-administered questionnaire responses.

Based on responses to the OIG's staff questionnaire, the OIG determined that facility employees generally have positive perceptions about their ability to improve their work environment and feel safe making suggestions to improve processes or report safety issues when needed. In interviews, executive leaders reported encouraging employees to speak up and take the right

[32] 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.

[33] 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.

actions to address patient safety concerns. For example, the Director detailed a situation when employees took initiative rather than waiting for direction from executive leaders: after someone broke into and vandalized one of the community-based outpatient clinics, the acting Chief of Police and an administrative officer cleaned up the damage, so the clinic was safe to open before employees and veterans arrived the next day. The Chief of Staff explained that leaders empower employees to focus on taking care of veterans and each other. Additionally, the chief shared that to create an environment where people can learn rather than fear blame, executive leaders send employees thank-you cards for raising patient safety concerns.

The Director acknowledged that a few departments were experiencing challenges with employee morale and lower All Employee Survey scores. The Director explained that executive leaders provide additional support to employees in those departments by mentoring supervisors and helping them develop strategies to support their employees. The Associate Director of Employee Engagement cited ongoing improvements in All Employee Survey scores and positive responses to the VA employee exit survey.[34] The OIG noted executive leaders' efforts to improve employees' experiences and made no recommendations.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[35] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[36] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In a panel interview with executive leaders, the Director stated the facility's congressional liaison and Director, when available, meet with VSOs to hear veterans' questions and concerns and work toward resolving any issues discussed. In addition, the Assistant Director shared that patient advocates involve staff in addressing veterans' concerns and inform them of the outcome.

When discussing the PACT Act, the Director, Chief of Staff, and Assistant Director acknowledged rapid growth of the veteran population throughout the facility's coverage area, particularly in rural areas, as a concern. The Assistant Director and Director explained that many veterans live in rural areas without a local VA facility and with limited community care

[34] VHA policy requires that facilities offer all employees who are voluntarily separating from VA, to include retirement, resignation, and transfer to another Federal agency, the opportunity to complete a VA Exit Survey. VA Handbook 5004, *VA Entrance, Exit and Transfer Surveys*, May 2, 2022.

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

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

options.[37] Therefore, executive leaders work closely with county commissioners and other federal agencies to lease underused government space to establish VA care in these locations.

The OIG found that executive leaders are communicating with VSOs and working to meet the care needs of veterans who live in rural areas. The OIG made no recommendations.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[38] The OIG examined the general entry touchpoints, which are features that assist veterans in accessing the facility and finding their way around. To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints, including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[39] 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

[37] "VA provides care to Veterans through community providers when VA cannot provide the care needed" "Community Care," Department of Veterans Affairs, accessed April 11, 2024, https://www.va.gov/communitycare/.

[38] VHA Directive 1608(1).

[39] 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.

evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[40]

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.

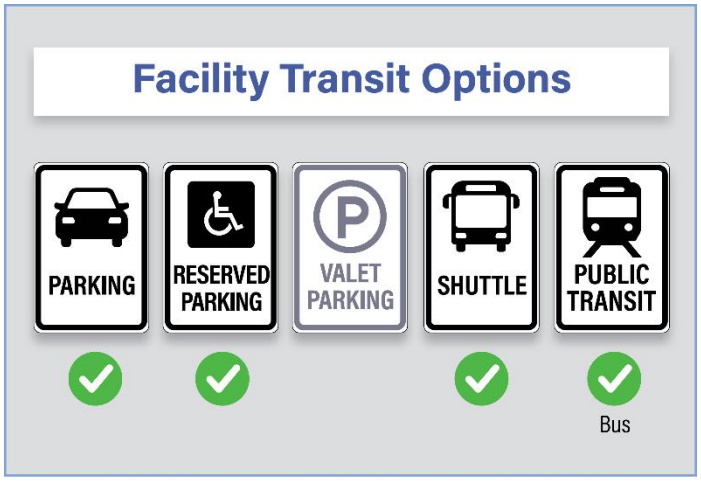


Figure 8. *Transit options for arriving at the facility. Source: OIG observation.*

The facility offers a parking lot and two multilevel parking garages (garages A and B). During an interview with members of the Comprehensive Environment of Care Committee, the OIG learned that executive leaders had authorized staff to convert some general parking lot spaces to be accessible for those with disabilities to allow easy access to the Emergency Department, main, and patient entrances.

When exiting garage A to access the facility, the OIG observed a nearby enclosed shelter with a golf cart and multiple wheelchairs. The Chief, Customer Service shared that staff use golf carts to transport patients to the facility. A nursing service representative referred to the area as the Welcome Center and said two patient escorts are available during business hours. However, on multiple occasions during the site visit, the OIG observed that patient escorts left the Welcome Center unattended and posted a sign with unidentified phone numbers, presumably for patients to call for assistance.

The Chief, Engineering told the OIG that staff remodeled garage B in December 2022, providing three additional parking decks. The OIG observed a ground-level area near garage B that did not have a defined crosswalk or signage for pedestrians entering and exiting. The Deputy Chief of Police explained that the area is not a formal crossing zone, and an officer is there to assist with traffic when available. The Chief of Engineering acknowledged the potential safety hazard and reported plans to address the pedestrian crosswalk during an upcoming project.

[40] 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.

The OIG did not identify issues with adequate parking. However, the OIG is concerned about the lack of a crosswalk and recommends executive leaders evaluate options to improve safety at the informal crossing area near parking garage B.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[41]

The facility has a patient entrance and main entrance (see figure 9). The OIG observed that veterans primarily used the patient entrance to access the facility.

Figure 9. *Facility front entrances.*
Source: Photo taken by OIG inspector.

The patient entrance was easily accessible with adjacent parking. The entrance featured power-assisted doors, a safe and accessible curb for visitors to pick up or drop off passengers, and readily available wheelchairs. The OIG noted the entrance was staffed with patient escorts and Red Coat Ambassadors who assist with directions. The OIG made no recommendations.

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.[42]

The OIG used the facility's internet site to verify directions to the facility and found the instructions easy to follow. However, the signage directing veterans where to park was partially

[41] 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*.

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

obstructed. The OIG also noticed the directories were not up to date, which could be a challenge for veterans to navigate from one location to another. The Comprehensive Environment of Care Committee said that leaders relocated multiple clinics because of the COVID-19 pandemic but did not update the directories throughout the facility. Additionally, the information desk near the main entrance only offered a pamphlet displaying an exterior view of the facility and did not have directions to clinic locations. Wrong or misleading directories may cause veterans to get lost and arrive late for their scheduled appointments.

When asked about opportunities to improve the facility's navigational cues, committee members shared plans to implement a digital map system, subject to the Director's approval. The OIG recommends that executive leaders ensure all directories are accurate and provide specific details so veterans can easily navigate the facility.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[43] The OIG found limited design features to support veterans with sensory impairments. The patient entrance lacked specific visual and auditory features like braille or audio instructions, but the OIG confirmed both were available in elevators.

The Chief, Customer Service reported requiring volunteers to complete annual training on communicating with sensory-impaired veterans. However, when the OIG asked the patient escorts, they denied being required to complete a similar training. When veterans with sensory impairments lack access to more visual or auditory design features, like sign language

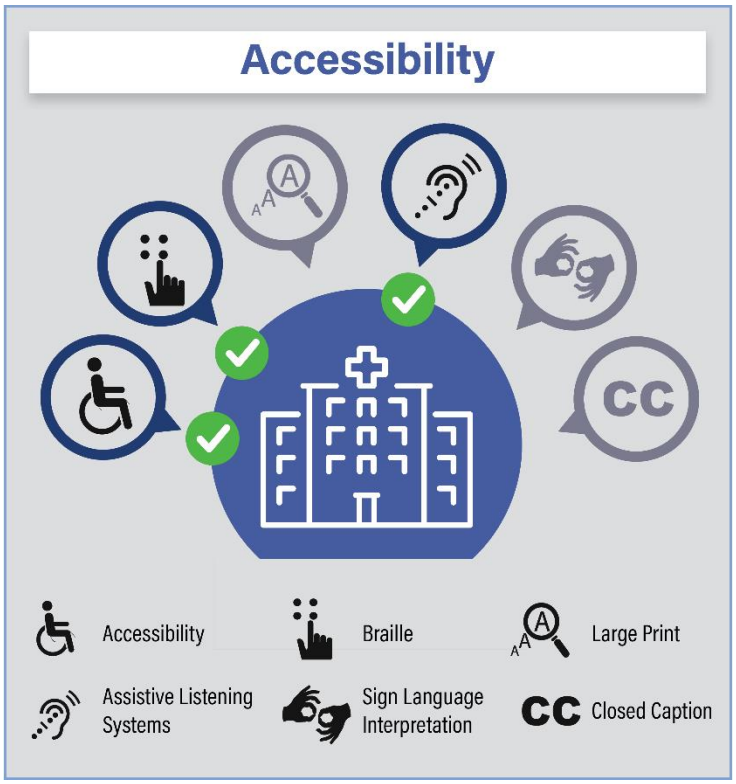


Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

[43] 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.

interpretation services and acoustic ceiling tiles, they may be unable to find their way around the facility and feel staff are not acknowledging their needs.

The OIG recommends that executive leaders implement additional features to aid veterans with sensory impairments to navigate the facility. The OIG also recommends that executive leaders ensure staff train patient escorts on how to effectively communicate with sensory-impaired veterans.

Toxic Exposure Screening Navigators

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

The OIG verified that the facility had three toxic exposure screening navigators. During an interview, a toxic exposure screening navigator confirmed that two navigators were located at the main campus and one at the Hillendale Road VA Clinic. During the inspection, the OIG found that volunteers at the information desk distributed toxic exposure screening handouts to veterans entering the facility. The volunteers also provided OIG team members with the instructions to request a toxic exposure screening.

While interviewing one of the navigators, the OIG learned that staff could screen veterans during primary and some specialty care appointments or when they call the facility's toxic exposure screening hotline. The navigator said there is no wait time for veterans to receive an initial screening, and the average time to complete a secondary screening, if required, is one business day.

The navigator also suggested that some veterans may be unaware they are eligible for VA health care under the PACT Act. In response, the navigator reported identifying veterans with potential exposure and planning outreach activities to contact and educate them on the expanded benefits and free medical evaluations. The OIG made no recommendations.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[45] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations

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

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

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 inspection findings. However, during an interview with the Comprehensive Environment of Care Committee, the OIG found no substantial evidence the committee had a process to review inspection findings for trends, as part of continuous process improvement to ensure patient safety. The Associate Director acknowledged this vulnerability and said the committee had started reviewing the top inspection findings to create sustainable action plans to resolve the deficiencies. The OIG expects leaders to ensure the committee reviews environment of care inspection findings to identify trends and opportunities to mitigate risks to ensure patient safety. The OIG recommends that executive leaders ensure the Comprehensive Environment of Care Committee reviews environment of care deficiencies for trends and opportunities for improvement.

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 team inspected the community living center, Emergency Department, primary care clinic, and the inpatient medical/surgical and intensive care units. While inspecting the Emergency Department, the OIG discovered high-alert medications in an unsecured location.[46] The Joint Commission requires staff to store all medications in a secure or locked area.[47] The nurse manager explained that the refrigerator where staff store these medications and the automated medication dispensing system were not linked, meaning staff could remove medications from the refrigerator without accessing the system to unlock it, and pharmacy leaders were aware of the situation. The Associate Chief of Pharmacy said they had contacted the automated medication dispensing system vendor and planned to work with them to fix the problem. The OIG team made several additional visits to the department while on-site to verify the medications were secured and noted staff implemented a temporary process to secure the medications two days after the OIG identified the issue. Although this action secured the medications temporarily, the OIG noted a continued vulnerability regarding safety for high-alert

[46] VA defines a high-alert medication as "a drug that bears a heightened risk of causing significant adverse events that cause harm to a patient." "Examples of high-alert medications include warfarin, opioids, insulin, anti-arrhythmics, lithium, chemotherapy, and immunosuppressive agents." VHA Directive 1310(1), *Medical Management of Enrolled Veterans Receiving Self-Directed Care From External Health Care Providers*, October 4, 2021, amended April 13, 2022.

[47] The Joint Commission, *Standards Manual*, E-dition, MM.03.01.01, January 14, 2024.

medications. The OIG recommends that executive leaders ensure staff store all high-alert medications in a secure or locked area.

VHA requires storage rooms to be clean and free of expired supplies.[48] The OIG found multiple storage rooms with expired medical supplies and accumulated dust on the protective barriers between the floor and supply shelving. The Chief, Supply Chain Management reported that staff implemented a return bucket process for expired items and a checklist to validate supply room cleanliness. The OIG recommends that executive leaders ensure staff follow their processes to prevent the storage of expired medical supplies and that supply areas remain clean.

VHA also requires VA medical facilities to have a safe and clean environment.[49] The OIG observed that staff had installed adhesive signage on floors and furniture throughout the facility to promote social distancing during the pandemic, but some signs were now worn and peeling, making it difficult to properly disinfect the areas and posing an infection risk. The OIG recommends that executive leaders ensure staff keep the facility free of temporary signage that may interfere with cleaning and disinfection processes.

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.

[48] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[49] VHA Directive 1608(1).

[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.

The OIG noted that diagnostic and laboratory leaders had policies and processes for notifying providers and patients of critical test results and tracking communications. In interviews, the leaders said staff within their department track timely communication of abnormal results to ordering providers.

The OIG reviewed radiology data for FY 2023 and found that diagnostic providers consistently communicated critical test results to ordering providers within 30 minutes of the results being available. However, the Associate Chief of Staff, Ambulatory Care Service (primary care) reported challenges with laboratory or radiology staff communicating abnormal results to ordering providers from community-based outpatient clinics or after clinic hours. The leader said they follow the after-hours provider contact list until someone is reached.

During interviews, leaders said service chiefs monitor providers' compliance with communicating abnormal test results to patients timely using view alerts, which are notifications in electronic health records, and as part of their Ongoing Professional Practice Evaluation process.[52] Leaders also stated that service chiefs monitor unread alerts, and if a provider has more than 300, it may indicate they are not communicating timely with their patients. In such cases, the service chief would work with the provider to resolve the alerts and may place them on a focused review or an improvement plan for closer monitoring. In addition, VISN leaders and facility primary care leaders meet monthly to discuss any providers who have more than 500 unread alerts and the actions taken to address providers' delay in responding to alerts.

Of note, the acting Chief, Quality Management acknowledged the facility does not have a hospital-wide method for quality management staff to validate service chiefs' processes for monitoring providers' compliance with communicating abnormal test results to patients and relies on external reviews, where an outside agency reviews a random sample of cases, to determine if providers are meeting criteria.[53] The OIG recommends that executive leaders ensure quality management staff implement an oversight process to validate providers' compliance with patient communication and follow-up for urgent, noncritical abnormal test results.

VA facilities use an electronic application, the Joint Patient Safety Reporting system, for staff to submit patient safety events, including adverse events and close calls. The VHA National Center for Patient Safety uses the reporting system as its primary source for learning about

[52] The Ongoing Professional Practice Evaluation process is used to monitor a licensed independent health care practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[53] The external review is a system process that supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. VHA Office of Informatics and Analytics, "External Peer Review Program (EPRP)," March 15, 2022, accessed April 11, 2024, https://department.va.gov/FY22ExternalPeerReviewProgram.pdf. (This website is not publicly accessible.)

vulnerabilities across medical facilities to prevent future adverse events.[54] The OIG reviewed the facility's patient safety events entered into the system and other quality reviews, such as root cause analyses, and noted a concern with delays in ordering providers communicating and following up with patients for abnormal and critical test results, which included four events that had institutional disclosures.[55]

Of the four institutional disclosures reviewed, the OIG found the ordering provider's lack of prompt attention to one patient's abnormal laboratory results may have contributed to the patient's death. In the other three cases, the OIG noted that patients with cancer had experienced a delay in test result notification, timely follow-up, or both. The OIG also noted that quality management staff did not enter three of the four patient safety events that resulted in institutional disclosures into the Joint Patient Safety Reporting system. Staff explained they did not enter the events in the reporting system because there is no policy requiring them to. However, VHA identifies patient safety managers as being responsible for "ensuring JPSR [Joint Patient Safety Reporting system] is used for the initial assessment of [the] patient safety event…to determine the level of harm associated with the event" and the required action.[56] Therefore, the OIG would expect the patient safety manager to confirm staff enter known adverse patient events in the reporting system and ensure the quality and accuracy of the data, so executive leaders can make informed decisions to improve patient safety. The OIG recommends the patient safety manager confirms staff enter known patient safety events into the Joint Patient Safety Reporting system for use in the initial assessment of these events.

[54] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[55] An institutional disclosure "is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. A root cause analysis is a comprehensive and focused review that is used for all "adverse events and close calls" requiring analysis. VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[56] Adverse events and close calls are assigned a safety assessment code score based on the severity of the event and "probability of harm" using "a risk score of 1, 2, or 3 (1 = Lowest Risk; 2 = Intermediate Risk; and 3 = Highest Risk,)." VHA Directive 1050.01(1).

Action Plan Implementation and Sustainability

Figure 11. *Status of prior OIG recommendations.*
Source: OIG analysis of documents.

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

Quality management staff reported that accrediting and oversight agencies did not issue recommendations to the facility in the past three years related to test result communications. However, the OIG noted the facility had one of eight recommendations open from the prior FY 2021 OIG review related to staff completing required prevention and management of disruptive behavior training.[58] VHA requires all staff to receive prevention and management of disruptive behavior training within 90 days of hire; training requirements are based on the risk level assigned to their work area.[59] The acting Chief, Quality Management said the pandemic, the vacant prevention and management of disruptive behavior coordinator position, and some staff requiring face-to-face trainings were all barriers to meeting the expectation. The acting chief added that leaders filled the coordinator position and disruptive behavior trainers work closely with supervisors to ensure staff are scheduled and receive the required training. Following the on-site review, staff submitted evidence to demonstrate compliance, and the OIG closed the recommendation on March 14, 2024. The OIG made no new recommendations.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[60] 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.[61] The OIG examined the

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

[58] VA OIG, *Comprehensive Healthcare Inspection of the Durham VA Health Care System in North Carolina*, Report No. 21-00276-67, February 3, 2022.

[59] Deputy Under Secretary for Health for Operations and Management (10N), "Update to Prevention and Management of Disruptive Behavior (PMDB) Training Assignments," memorandum to Veterans Integrated Service Network Directors (10N1-23) and Medical Center Directors (00), February 24, 2020.

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

[61] VHA Directive 1050.01(1).

facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Patient safety managers can generate reports from the patient safety reporting system to inform leaders of safety event themes. Quality management staff stated they review safety events from the previous day with executive leaders, and the Director also maintains an electronic dashboard of events requiring follow-up. Staff said they do not have a process for reviewing safety events to identify recurring issues and rely on their memory. However, if they identify themes, they discuss them with the Chief, Quality Management and executive leaders to determine the next course of action, such as conducting a root cause analysis.

To become an HRO, the OIG expects quality management and patient safety staff to review patient safety events to identify recurring themes and mitigate future occurrences to promote a culture of zero harm. The OIG recommends that executive leaders ensure staff review patient safety events for trends and system vulnerabilities and implement process improvement actions to prevent future occurrences.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[62] 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.[63] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[64] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The facility offers primary care services through outpatient clinics located in Clayton, Croasdaile, Durham, Greenville, Morehead City, and Raleigh, North Carolina. Additionally,

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

[63] 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).

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

there are two women's health primary care clinics in Durham and Greenville, North Carolina. The Associate Chief of Staff for primary care confirmed that the outpatient clinics had 84 primary care teams available to support veterans in the coverage area. However, the OIG identified several vacant positions: 10 primary care provider, 7 registered nurse, 14 licensed practical nurse, and 7 medical support associate positions; provider vacancies were in the Greenville, Morehead City, and Raleigh clinic locations.

The Associate Chief of Staff for primary care said these vacancies are mostly due to employee retirements or losses to non-VA hospitals. The primary care leader added that recruiting and retaining qualified providers in Greenville and Morehead City is a challenge due to the rural location. In addition, the Associate Director for Patient Care Service reported a decline in the applicant pool of licensed practical nurses, attributing it to several factors like the decreasing number of training programs, lower VA salaries compared to those in non-VA hospitals, and the lack of flexible work schedules.

Primary care leaders stated that registered nurses and medical support associates cover more than one team and leaders partnered with the VISN 6 Clinical Resource Hub to receive staffing support at the facilities facing recruitment challenges. For example, a Clinical Resource Hub provider has been working at the Morehead City clinic the past two years. In addition, primary care leaders told the OIG that executive leaders were aware of the vacancies and supported recruitment and retention incentives, including pay increases and student loan repayment.

Despite vacancies, the OIG found no significant issues with primary care team workflows and patient access. The OIG suggests that executive leaders continue to address staffing shortages in primary care teams to ensure patients have timely access to care. The OIG made no recommendations.

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.[65] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[66]

The OIG determined that on average, the primary care team panel capacity was about 82 percent full from October through December 2023, which meant some providers had room to add new patients to their current panels. The Primary Care Management Module Coordinator reported meeting with primary care leaders to regularly discuss providers' panel capacity and patient growth patterns to ensure teams are efficient. According to the Associate Chief of Staff for

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

[66] VHA Directive 1406(1).

primary care, new providers will increase the number of patients seen over time to optimize panel size.

Primary care staff told the OIG that panel size and leave coverage expectations are reasonable, allowing them to assist other teams and accept new patients as needed. Staff described facility leaders as being responsive to their concerns, and support staff reported feeling heard by their supervisors. The OIG made no recommendations.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[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 leaders and team members identified limited space, and competing demands as the major issues that affect clinic processes. Clinical staff offer veterans both in-person and virtual appointments to address the limited clinical space. The Associate Chief of Staff for primary care highlighted competing demands for the primary care providers, such as addressing clinical reminders and performing preventive and toxic exposure screenings.[68] Primary care leaders stated that informatics staff support their efforts to improve efficiency by sorting clinical reminders by priority; grouping orders based on a condition or disease; and showing normal laboratory values and definitions in the electronic health record, which aid providers in their decision-making processes.

Primary care leaders and staff discussed several process improvement projects to optimize clinic workflow, which included implementing a primary consult hub, which allows support staff to see all providers' availability and use any open appointment time for new patients rather than only the assigned provider. The OIG made no recommendations.

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. The OIG found the facility had higher veteran enrollment in FY 2023 than the prior three FYs. According to the Associate Chief of Staff for primary care, veteran enrollment at the Durham outpatient clinic is stable. Therefore, when a primary care provider leaves the clinic, leaders reassign patients to other care teams and the team members to other clinics with shortages in primary care.

[67] VHA Handbook 1101.10(2).

[68] Preventive screenings include cancers, mental health conditions, tobacco use, immunizations, health education, and preventive medications for selected high-risk conditions. VHA Handbook 1101.10(2).

Despite the staffing shortages, new patient appointment wait times were less than 20 days in FY 2023 and FY 2024 through February 2024. Primary care leaders attributed this to staff working together; having information on which team could see the patient at the earliest available appointment; and using different modalities of care, such as face-to-face, secure video conferencing, and telephone visits. Furthermore, clinic staff reported having to complete an additional clinical reminder, the toxic exposure screen, which increases the time from the patient's point of intake to when they see the provider.

During the primary care team interview, the OIG found that the PACT Act was associated with increased veteran enrollment and that toxic exposure screenings added 10 minutes to primary care visits but did not negatively affect access to care. The OIG made no recommendations.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[69]

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]

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

[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.

The VHA Homeless Programs Office did not require facility staff to monitor the engagement of unsheltered veterans during FYs 2021 through 2023 due to the low number of unsheltered veterans identified in the coverage area. The HCHV outreach coordinators reported participating in the annual point-in-time count event, where VA and community agency staff walk around the city and count the number of people experiencing homelessness on a single night.

The coordinators also discussed collaborating with community partners to host a yearly outreach event called Stand Down. During the event, veterans can receive food, clothing, health care, and legal aid. Staff also conduct intake assessments to identify and enroll veterans into the HCHV program or refer them for other VA resources.

The coordinators described the difficulty in obtaining veterans' personal information, such as identification, social security numbers, military discharge papers, and proof of income as an obstacle to enrollment because some homeless veterans may not have easy access to this information, requiring staff to contact eligibility offices and national archives. The OIG made no recommendations.

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).[72]

[72] 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 exit) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

The OIG found that the HCHV program successfully met the HCHV1 measure target each year from FYs 2021 through 2023 but only met the HCHV2 target in FY 2022. To explain why the program did not meet the HCHV2 target in FYs 2021 and 2023, the HCHV outreach coordinators reported that some veterans who were in contracted residential services heard about other community housing opportunities and left the program without seeking guidance from HCHV staff.

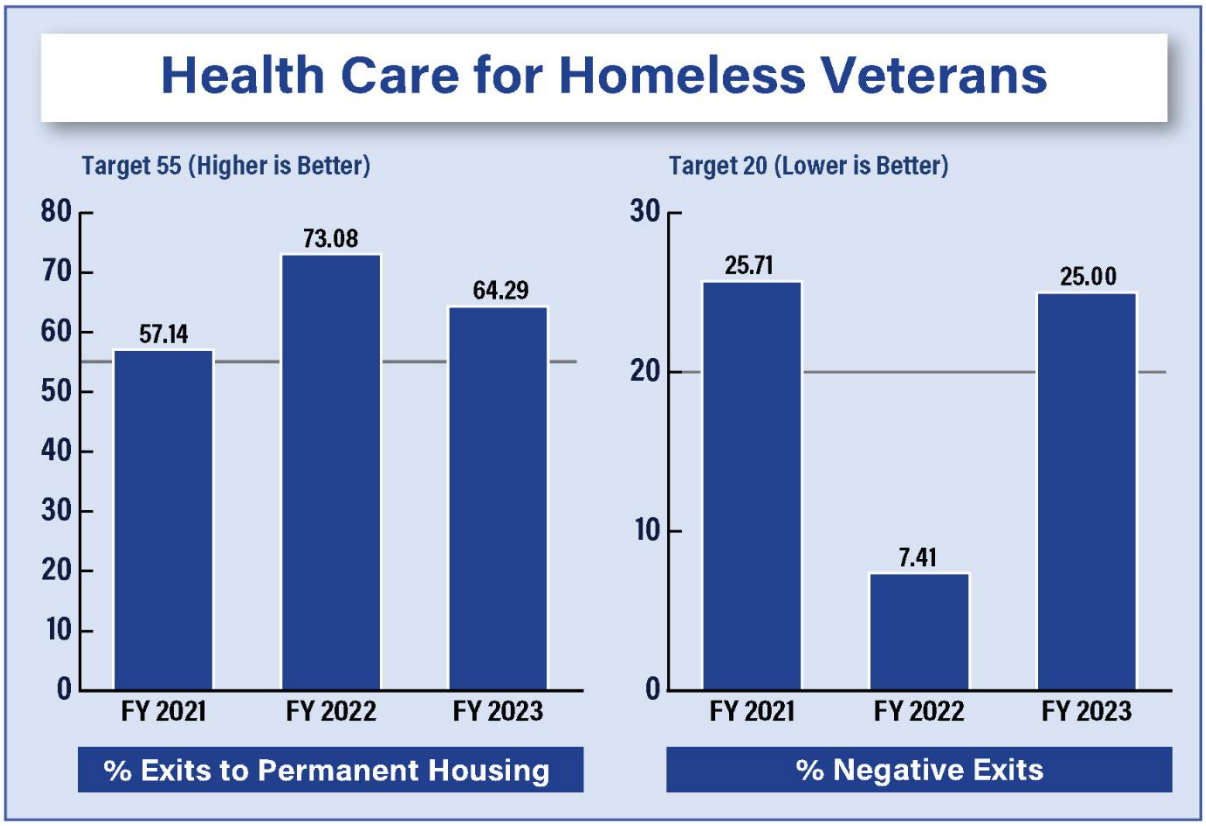


Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The outreach coordinators explained that they spend a significant amount of time with veterans to determine their eligibility for the program based on VA criteria like veteran and discharge status, length of service, and when the veteran served. During the pandemic, the coordinators reported receiving funds from the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 to provide temporary lodging and over 200 cell phones to veterans in need.[73] Now that the funding has ended, coordinators expressed concerns about limited financial support and said

[73] Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136, 134 Stat. 281 (2020). The Coronavirus Aid, Relief, and Economic Security (CARES) Act (2020) was "signed into law on March 27, 2020," and "provided fast and direct economic assistance for" Americans "to address issues related to the onset of the COVID-19 pandemic." "About the CARES Act and the Consolidated Appropriations Act," Department of Treasury, accessed March 20, 2024, https://home.treasury.gov/policy-issues/coronavirus/about-the-cares-act.

they have resorted back to the pre-pandemic practice of seeking funds and assistance from community partners.

The coordinators also stated that prior to the pandemic, the program was able to leverage an apartment complex that received grants from VA to house veterans experiencing homelessness. The apartment complex accepted veterans regardless of their credit history or income, which provided temporary housing until they could secure permanent housing. However, this resource is no longer available since the apartment complex did not renew its grant application. HCHV outreach coordinators explained that following the pandemic, housing prices increased substantially, and veterans' lack of income and rental history makes it difficult for them to secure housing.

Figure 13. *Facility's current community partnerships.*
Source: OIG interviews.

The coordinators described ongoing efforts to build and sustain relationships with community partners to provide housing, organize Stand Down events, and offer financial support for veterans' housing needs. Coordinators also explained that their communication with existing community partners was stronger before the onset of the COVID-19 pandemic, and due to community partner staff turnover, they had to rebuild relationships and establish new networks. The OIG made no recommendations.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[74] 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.[75]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering veterans justice programs each fiscal year (performance measure VJP1).[76] The facility met and exceeded its target for veterans entering the program in FY 2023. However, the Veteran Justice Outreach Specialist expressed that the measure does not capture the number of veterans involved with the criminal justice system that program staff consult with but do not enroll in the program. The specialist also said that jail representatives do not consistently notify program staff when they have veterans, which hinders enrollment opportunities. Therefore, the specialist focused on relationships with jails; sheriff's, public defender's, and district attorney's offices; and probation departments; resulting in better notification rates. The specialist described using the Veterans Re-Entry Search Service website to identify veterans and connect them to the program, but said community partners are not leveraging this tool.[77] The specialist acknowledged that staff miss opportunities to enroll veterans in the program when correctional facilities release veterans before staff can obtain permission to visit, but they are developing relationships with correctional facility leaders to gain more timely access. The OIG made no recommendations.

Meeting Veteran Needs

According to the Veteran Justice Outreach Specialist, program enrollees have various needs such as obtaining mental health and substance abuse treatment; accessing health care; reducing risk factors for relapse and mortality; and securing safe and stable housing, employment, and income. The specialist described several barriers to meeting veterans' needs. First, staff have to rely on the only veterans treatment court in Harnett County, but two additional counties (Rockingham

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

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

[76] 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*.

[77] The Veterans Re-Entry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military" "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) - Terms and Conditions of Use" Department of Veterans Affairs, accessed April 11, 2024, https://vrss.va.gov. (This website is not publicly accessible.)

and Pitt) are establishing veterans treatment courts in their areas.[78] Second, the program only has two full-time staff to cover a large geographical area; however, the program supervisor is aware and pursuing efforts to hire additional staff. Lastly, there is limited availability of legal services for families. The specialist further explained that it has been challenging since the pandemic for staff to re-establish communications with legal providers, but they continue attempts to contact and work with those providers to resume the services. The OIG made no recommendations.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[79] 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.[80]

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).[81] The OIG found that the facility's program did not meet the performance measure target from FYs 2021 through 2023. The program coordinator discussed several challenges to meeting the target. The coordinator reported having two vacant positions in FY 2023, and although leaders have hired four new staff members, it takes time for them to learn their job and develop relationships with landlords.

Additionally, the coordinator said landlords and property managers stopped accepting housing vouchers or sold their properties following the pandemic, which resulted in limited affordable

[78] Veterans treatment courts "effectively integrate evidence-based substance use disorder treatment, mandatory drug testing, incentives and sanctions, and recovery support services in judicially supervised court settings that have jurisdiction over veterans involved in the justice system who have substance use disorders, including a history of violence and post-traumatic stress disorder as a result of their military service." "Veterans Treatment Court Program, Overview," Department of Justice, accessed April 21, 2024, https://bja.ojp.gov/program/veterans-treatment-court-program/overview.

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

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

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

housing options.[82] To address this issue, the program coordinator shared a plan to organize an engagement event in FY 2024 to provide landlords with information about the program and encourage them to participate.

The program coordinator informed the OIG that veterans can enroll in the program through the homeless program call center, a walk-in clinic held at the medical center most weekdays, and via consults placed by VA providers. The coordinator added program staff assess veterans' immediate needs and provide them with information on resources, such as homeless shelters or programs for immediate financial assistance. The OIG made no recommendations.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[83] The OIG found that the facility has not met the performance measure target each year from FY 2021 through FY 2023. The Housing and Urban Development–Veterans Affairs Supportive Housing Program Coordinator reported that the program's deployment specialist has been instrumental in assisting veterans with building resumes, preparing and dressing for interviews, and securing employment. In addition, the specialist holds a weekly group session to provide veterans with information on potential employment opportunities.

The coordinator reported that there are not enough resources for women in the area, such as homeless shelters, and that an on-site domiciliary would help meet veterans' needs.[84] The coordinator also said that program staff are identifying other public housing authorities to expand housing options for veterans. The coordinator acknowledged several community partners that assist with furniture, administrative and application fees, rental deposits, first month's rent, utilities, and payment of past due rental fees to prevent eviction.

The coordinator also reported challenges in helping veterans who are unable to live independently due to health and safety issues to secure available housing options. Therefore, staff collaborate with VA Geriatrics and Extended Care leaders to identify alternative housing

[82] The housing vouchers program "is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market." "Housing Choice Vouchers Fact Sheet," Department of Housing and Urban Development, accessed April 11, 2024, https://www.hud.gov/topics/housing_choice_voucher_program_section_8.

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

[84] "The Domiciliary has evolved from a 'Soldiers' Home' to become an active clinical rehabilitation and treatment program for male and female Veterans." "VA Homeless Programs, Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed April 22, 2024, https://www.va.gov/homeless/dchv.asp.

options for veterans, such as assisted living facilities and skilled nursing and medical foster homes.[85]

The program coordinator explained that a process improvement workgroup is completing a needs assessment to determine whether there is a strategic case to recommend establishing a Community Resource and Referral Center. The coordinator elaborated, saying the center would provide veterans who are homeless or at risk of homelessness with one-stop access to community-based, multi-agency services to assist with permanent housing, health care, and mental health services. The coordinator said a Community Resource and Referral Center located in downtown Durham could allow program staff to reach more veterans who would not otherwise come to the main facility. The OIG made no recommendations.

Conclusion

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

[85] Skilled nursing is "care that can only be safely and effectively performed by, or under the supervision of professionals." "Skilled Nursing Facility (SNF) Care," Medicare.gov, accessed April 22, 2024, https://www.medicare.gov/coverage/skilled-nursing-facility-snf-care. "Medical foster homes are private homes in which a trained caregiver provides services to a few individuals." "Geriatrics and Extended Care, Medical Foster Homes," Department of Veterans Affairs, accessed April 11, 2024, https://www.va.gov/Geriatrics/pages/Medical_Foster_Homes.asp

Summary of Findings and Recommendations

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

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

Critical

Finding: The OIG found that facility staff did not secure high-alert medications in the Emergency Department as required. The OIG also observed multiple areas with expired medical supplies and worn and peeling signage on floors and furniture throughout the facility.

Recommendation 1: The OIG recommends that executive leaders ensure staff store all high-alert medications in a secure or locked area.

Recommendation 2: The OIG recommends that executive leaders ensure staff follow their processes to prevent the storage of expired medical supplies and that supply areas remain clean.

Recommendation 3: The OIG recommends that executive leaders ensure staff keep the facility free of temporary signage that may interfere with cleaning and disinfection processes.

Finding: The OIG determined that staff did not enter three of the four patient safety events that resulted in institutional disclosures into the patient safety reporting system.

Recommendation 4: The OIG recommends that the patient safety manager confirms staff enter known patient safety events into the Joint Patient Safety Reporting system for use in the initial assessment of these events.

Finding: Facility leaders did not have a hospital-wide method for quality management staff to validate service chiefs' process for monitoring providers' compliance with communicating abnormal test results to patients.

Recommendation 5: The OIG recommends that executive leaders ensure quality management staff implement an oversight process to validate providers' compliance with patient communication and follow-up for urgent, noncritical abnormal test results.

Major

Finding: The OIG observed the ground-level area near garage B did not have a defined crosswalk or signage for pedestrians entering and exiting, which creates a safety hazard.

Recommendation 6: The OIG recommends executive leaders evaluate options to improve safety at the informal crossing area near parking garage B.

Finding: During the COVID-19 pandemic, facility leaders relocated multiple clinics but did not update the directories and maps, which could be a challenge for veterans to navigate from one location to another.

Recommendation 7: The OIG recommends that executive leaders ensure all directories are accurate and provide specific details so veterans can easily navigate the facility.

Finding: The facility had limited design features throughout to assist the navigation experience of veterans with sensory impairments, and patient escorts did not receive training on how to best communicate with sensory-impaired individuals.

Recommendation 8: The OIG recommends that executive leaders implement additional features to aid veterans with sensory impairments to navigate the facility.

Recommendation 9: The OIG recommends that executive leaders ensure staff train patient escorts on how to effectively communicate with sensory-impaired veterans.

Finding: The Comprehensive Environment of Care Committee did not review inspection findings for trends, as part of continuous process improvement to ensure patient safety.

Recommendation 10: The OIG recommends that executive leaders ensure the Comprehensive Environment of Care Committee reviews environment of care deficiencies for trends and opportunities for improvement.

Finding: The facility's quality management and patient safety staff do not review patient safety events to identify recurring themes and mitigate future occurrences to promote a culture of zero harm.

Recommendation 11: The OIG recommends that executive leaders ensure staff review patient safety events for trends and system vulnerabilities and implement process improvement actions to prevent future occurrences.

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 active VSO representatives.[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.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from February 26, 2024, through February 29, 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, 2020, through September 30,2023.

[2] The OIG received a response from one VSO: Orange County North Carolina Veteran Services.

[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. Facility in Context Data Definitions*

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

Category	Metric	Metric Definition
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented 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.

Category	Metric	Metric Definition
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

Table B.2. Health of the Veteran Population*

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

Category	Metric	Metric Definition
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.
	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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 15, 2024

From: Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subj: Healthcare Facility Inspection of the Durham VA Health Care System in North Carolina

To: Director, Office of Healthcare Inspections (54HF05)

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

1. Thank you for the opportunity to review the draft report of the Healthcare Facility Inspection of the Durham VA Health Care System in North Carolina.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Durham VA Medical Center. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

(Original signed by:)

Jonathan Benoit
Deputy Network Director

For
Paul S. Crews, MPH, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 30, 2024

From: Director, Durham VA Health Care System (558/00)

Subj: Healthcare Facility Inspection of the Durham VA Health Care System in North Carolina

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review and respond to the draft report of the *Healthcare Facility Inspection of the Durham VA Health Care System in North Carolina.*
2. I have reviewed the report and concur with recommendations 1 through 9, and in principle for recommendations 10 and 11 in the draft report. Action plans have been developed or implemented and are identified in the Director Comments. I request the closure of recommendations 3, 4, and 6.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact Acting Chief, Quality and Patient Safety.

(Original signed by:)

Alyshia Smith, DNP
Executive Director

Appendix E: VA Responses

Recommendation 1

The OIG recommends that executive leaders ensure staff store all high-alert medications in a secure or locked area.

__X__Concur

_____Nonconcur

Target date for completion: December 31, 2024

Director Comments

The Durham VA Health Care System Chief of Pharmacy rounded in the Emergency Department (ED) on March 1, 2024. A FlexLock was installed on the medication refrigerator in the ED on March 8, 2024. The installed FlexLock is integrated with the Omnicell to enhance medication safety, linking medication retrieval to Omnicell sign-in and medication orders in CPRS [Computerized Patient Record System]. Monitoring for sustainment: Pharmacy rounds and inspections will occur in the ED medication storage areas monthly starting July 2024. Numerator: the number of passed medication inspections confirming all high alert medications are stored securely. Denominator: total number of medication inspections. Chief of Pharmacy will review compliance data and report monthly to Quality Patient Safety (QPS) Council for executive leadership oversight to ensure 90% compliance is achieved for six consecutive months.

OIG Comments

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

Recommendation 2

The OIG recommends that executive leaders ensure staff follow their processes to prevent the storage of expired medical supplies and that supply areas remain clean.

__X__Concur

_____Nonconcur

Target date for completion: April 30, 2025

Director Comments

The Durham VA Health Care System has an established process to prevent storage of expired or damaged medical supplies and to ensure cleanliness through inspection of supply areas.

Beginning November 5, 2024, the Durham VA Health Care System Supply Chain Management (SCM) staff will complete weekly inspections in supply areas, ensuring supply storage bins and shelves are free of dust and debris, and that expired or damaged items are removed and replaced as indicated. These checks will be documented on the weekly sign-off sheet in the supply areas.

Monitoring and sustainment: Audits of 10 inspection sheets per month will occur by the Chief of SCM to ensure supply storage bins and shelves are free of dust and debris, and that expired or damaged items are removed and replaced. Denominator: Number of inspection sheets audited; Numerator: Number of audits completed free of debris, dust, expired or damaged items. Corrections completed and noted on the sign-off sheet will be considered compliant. SCM Chief will audit the inspection logs and report monthly to Quality Patient Safety (QPS) Council for executive leadership oversight until 90% compliance is achieved for six consecutive months.

OIG Comments

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

Recommendation 3

The OIG recommends that executive leaders ensure staff keep the facility free of temporary signage that may interfere with cleaning and disinfection processes.

__X__Concur

_____Nonconcur

Target date for completion: October 15, 2024

Director Comments

The Durham VA Health Care System Quality and Patient Safety (QPS) and Integrated Strategic Communications Office (ISCO) team members completed environmental scans. Worn or peeling temporary signage and any signage that will interfere with cleaning and disinfection processes have been removed. To reduce the risk of damaging floors in the Emergency Department, a vendor has been secured to remove tape from floors on October 15, 2024. To reinforce signage etiquette, the facility wide newsletter published on October 4, 2024, included messaging for employees to remove all temporary signage and provided instructions for proper signage/poster etiquette. For sustainment, worn or peeling signage, or signage posted that will interfere with cleaning and disinfection will be identified and corrected during routine leadership environmental rounds. We request closure of this item.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

The OIG recommends that the patient safety manager confirms staff enter known patient safety events into the Joint Patient Safety Reporting system for use in the initial assessment of these events.

__X__Concur

_____Nonconcur

Target date for completion: November 1, 2024

Director Comments

The Durham VA Health Care System Facility Director and leaders fully endorse principles of high reliability and a culture of continuous improvement and learning. A key component of this high reliability organization (HRO) culture is reporting of patient safety events and close calls. The health care system Joint Patient Safety Reporting (JPSR) data are indicative of a learning culture and one focused on the principles of high reliability.

The local Institutional Disclosure (ID) checklist used by Risk Managers was revised February 28, 2024. Beginning March 4, 2024, a crosswalk of Patient Safety events and Institutional Disclosures (ID) cases was completed using the revised checklist, which includes an added column to confirm Joint Patient Safety Reporting (JPSR) has been entered for all ID cases and monitored monthly thereafter. As of February 2024, JPSR reporting has been entered for 100% of the institutional disclosure cases demonstrating more than 6 months of compliance. To ensure continued facility compliance, Risk Managers will provide a quarterly report of ID and JPSR data to Quality Patient Safety Council for leadership oversight. We request closure of this item.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

The OIG recommends that executive leaders ensure quality management staff implement an oversight process to validate providers' compliance with patient communication and follow-up for urgent, noncritical abnormal test results.

__X__Concur

_____Nonconcur

Target date for completion: April 30, 2025

Director Comments

The Chief of Staff ensures compliance with communication of urgent, noncritical abnormal test results to the patient. The Chief of Quality and Patient Safety (QPS) will implement a monthly audit on the follow up and communication of urgent, noncritical abnormal test results.
October 2024, QPS created an audit tool. Sixty randomized chart audits will be completed each month and chart audits will be performed by QPS staff. Monitoring and sustainment will include reporting of chart audits in QPS Council monthly beginning November 2024 until 90% compliance is achieved for six consecutive months and for leadership oversight.
Numerator: Number of charts with Veteran notification documented within required timeframes.
Denominator: Total number of charts reviewed.

OIG Comments

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

Recommendation 6

The OIG recommends executive leaders evaluate options to improve safety at the informal crossing area near parking garage B.

__X__Concur

_____Nonconcur

Target date for completion: September 25, 2024

Director Comments

The Durham VA Health Care System Chief of Safety, Chief of Engineering and Chief of Police evaluated the pedestrian crossing areas located near Parking Garage B. To improve pedestrian safety at uncontrolled pedestrian crossing locations near parking garage B, the following actions were completed:

1. Crosswalks near Garage B were marked on 9/18/2024.
2. Installation of Pedestrian Crossing Signage was completed on 9/25/2024.

We request closure of this item.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

The OIG recommends that executive leaders ensure all directories are accurate and provide specific details so veterans can easily navigate the facility.

__X__Concur

_____Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Health Care System Director collaborated with the Chief of the Integrated Strategic Communications Office (ISCO) to evaluate the current facility directories. Beginning the week of September 16, 2024, ISCO completed an evaluation of facility directories and identified revisions needed based on clinic relocations and organizational changes. By November 15, 2024, ISCO will meet with the facility planner and interior designer to obtain corrected information for the directories. ISCO will update directories to include corrected locations by January 31, 2025. Progress will be monitored monthly and reported to Quality Patient Safety Council beginning November 2024 for leadership oversight. Monitoring and sustainment: Monthly audit of 10 directories will be completed by ISCO or the Facility Planner until 90% compliance is achieved for six consecutive months. Numerator: number of correct directories; Denominator: number of directories reviewed.

OIG Comments

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

Recommendation 8

The OIG recommends that executive leaders implement additional features to aid veterans with sensory impairments to navigate the facility.

__X__Concur

_____Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Durham VA Health Care System Chief of Integrated Strategic Communication Office (ISCO) in consultation with Blind Rehabilitation Services will evaluate signage for Veterans with sensory impairments to navigate the facility. Signage assessment began the week of September 16, 2024. Coordinating with interior design and the Veterans Health Education Coordinator, ISCO will create updated signage at the main entrances and on directories to meet the needs of Veterans with sensory impairments by increasing font size for increased visibility and providing information for hearing impairment. ISCO will meet with EEO Program Manager to identify resources for Veterans with sensory impairments by January 31, 2025. Pamphlets will be developed with information for sensory impairment and distributed throughout the health care system by January 31, 2025. Information regarding sensory impairment resources will be added in employee newsletter by December 1, 2024. Monitoring and sustainment: ISCO or designee will complete monthly environmental rounds to monitor signage and features. Rounds data will be reported to Quality Patient Safety Council for leadership oversight, until 90% compliance is achieved for six consecutive months. Numerator: Number of sites or areas with compliant signage or aids for Veterans with sensory impairment; Denominator: Number of rounding sites.

OIG Comments

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

Recommendation 9

The OIG recommends that executive leaders ensure staff train patient escorts on how to effectively communicate with sensory-impaired veterans.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2025

Director Comments

The Durham VA Health Care System Facility Associate Director of Patient Care Services (ADPCS) will ensure patient escorts are trained to communicate with sensory-impaired Veterans. Staff from the Blind and Rehabilitation Services and Audiology and Speech Pathology services provided training materials on "Effective Communication to Veterans with Sensory-Impairment." The initial patient escort training was completed on 09/16/2024, 10/04/2024, 10/29/2024, and 10/30/2024. There are a total number of 34 patient escorts, and 33 out of 34 completed training, one patient escort is currently on extended leave and will be trained on return to duty. Quarterly training will be provided if new patient escorts are onboarded. New escorts will be trained by December 31, 2024, and as they onboard, quarterly thereafter. For monitoring and sustainment, training data will be provided to Quality Patient Safety Council monthly to ensure 90% compliance is maintained for six consecutive months and for leadership awareness. Numerator: Number of new escorts trained. Denominator: Number of new escorts onboarded.

OIG Comments

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

Recommendation 10

The OIG recommends that executive leaders ensure the Comprehensive Environment of Care Committee reviews environment of care deficiencies for trends and opportunities for improvement.

__X__Concur in principle

_____Nonconcur

Target date for completion: April 30, 2025

Director Comments

The Durham VA Health Care System Associate Director and Chief of Safety, through the Comprehensive Environment of Care Committee (CEOCC) meeting, reviews environment of care (EOC) deficiencies for trends and opportunities for improvement. Beginning November 2024, in addition to documenting the top deficiencies identified, the CEOCC minutes will reflect the actions to address the top 3 deficiencies. The Chief of Safety will monitor compliance monthly with a target of 90% compliance rate for six consecutive months. The numerator is defined as the number of monthly CEOCC meeting minutes with top deficiencies and action plans listed; the denominator is defined as the total number of CEOCC meeting minutes audited. Compliance will be reported by the Chief of Safety to the CEOCC for leadership oversight.

OIG Comments

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

Recommendation 11

The OIG recommends that executive leaders ensure staff review patient safety events for trends and system vulnerabilities and implement process improvement actions to prevent future occurrences.

__X__ Concur in principle

_____ Nonconcur

Target date for completion: April 30, 2025

Director Comments

The Durham VA Health Care System Chief of Quality and Patient Safety (QPS) and Quality management staff will continue to review and report patient safety event trends to the Quality Patient Safety (QPS) Council. Beginning October 2024, actions to address the top 2-3 events identified have been documented in QPS Council. The Chief of QPS will monitor compliance monthly with a target of 90% compliance rate for six consecutive months. The numerator is defined as the number of monthly QPS meeting minutes with top trends and action plans listed; the denominator is defined as the total number of QPS meeting minutes audited. Compliance will be reported to the QPS Council for leadership oversight.

OIG Comments

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

OIG Contact and Staff Acknowledgments

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