US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama

Healthcare Facility Inspection	24-00588-19	December 19, 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 Birmingham VA Health Care System during the week of March 11, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt daily operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. Leaders described the COVID-19 pandemic as a system shock and highlighted staff's resilience and hard work during that time. Leaders also explained the previous Director leaving unexpectedly three years earlier had been a system shock, which they addressed through transparent communication, positive messaging, and improvements to staff's daily experiences.

The OIG found that facility leaders placed a strong focus on recognizing and communicating openly with employees. Leaders also worked with the Equal Employment Opportunity Manager and human resources staff to increase workforce diversity and hired a Clinical Wellbeing Officer who works directly with employees in each department to address areas for improvement.[2] The OIG also found that leaders sought to foster employees' psychological safety by encouraging

[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] Government agencies may use special hiring authorities to target specific segments of the population such as veterans and those with disabilities. "Hiring Authorities," Office of Personnel Management, accessed August 2, 2024, https://www.opm.gov/policy/oversight/hiring-authorities.

them to report concerns.[3] In addition, patient advocates and veterans service organizations conveyed that there are mechanisms to provide direct feedback to facility leaders, who are responsive to veterans' concerns.

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 observed the facility had a welcoming main entrance that had assistive devices, such as wheelchairs, and an area with free coffee and seating. The OIG also observed a kiosk machine that veterans could use to print directions to specific clinic locations, and front desk personnel to assist as needed. However, the front desk personnel stated they had not received training to assist sensory-impaired veterans. The OIG made one recommendation.

During the physical inspection, the OIG found clean linen and soiled items stored together in two locations and identified a trend of general uncleanliness throughout the facility. Of note, during the fiscal year 2020 inspection, the OIG also observed clean and dirty equipment and supplies stored together and a trend of general uncleanliness. The OIG made two recommendations to address these issues.

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 Quality Management Director shared that recent external peer reviews revealed a trend of primary care providers failing to receive patients' test results from Emergency Department visits. The OIG found that staff were revising the facility policy to better specify communication responsibilities between ordering providers in the Emergency Department and the primary care providers. The OIG also found that, although staff had identified deficiencies in the communication of test results, they had not fully implemented action plans for improvement. The OIG made one recommendation to resolve this vulnerability.

[3] 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.

The OIG found several patient safety reports from the previous year that involved delays in communicating test results to ordering providers and patients. Leaders addressed the causes of those delays through educating staff and communicating expectations during a primary care department meeting. Although the OIG found staff did not evaluate common safety themes in patient safety data, leaders attributed this failure to previous staffing shortages in the quality management department. The OIG also noted that leaders were aware of deficient quality measures for the communication of some test results to patients but did not ensure staff implemented action plans for improvement. The OIG made a recommendation to address this issue.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[4]

The OIG found that position vacancies and increased workload had not resulted in significant increases in appointment wait times or delays in care. Leaders hired a physician recruiter to make the hiring process more efficient for new providers and to seek opportunities to recruit potential applicants. The leaders also partnered with a local nurse practitioner program to recruit potential applicants and approved pay increases for some positions to improve staff retention. The OIG found that primary care staff and leaders had developed several process improvement projects focused on improving primary care team efficiency. Additionally, despite an increase in veteran enrollment, primary care staff managed wait times by scheduling new patients based on provider availability and offering established patients same-day access to care.

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. Program staff identified difficulties with finding unsheltered veterans and accurately capturing veterans' housing status. The staff also shared that, despite some success in assisting veterans with obtaining stable housing, affordable options and landlords willing to participate in the program are limited. To combat these challenges, program staff meet weekly with community partners and hold annual events to share information and encourage more landlords to participate. The

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

OIG found the facility had active homeless and Veterans Justice Programs that had a strong emphasis on outreach services and collaborated with multiple community partners.

What the OIG Recommended

The OIG made four recommendations for improvement.

1. The Veterans Integrated Service Network leaders ensure facility staff separate clean and dirty equipment and supplies to prevent cross-contamination.
2. The Veterans Integrated Service Network leaders ensure facility staff keep the environment clean and safe.
3. Executive leaders ensure front desk personnel are competent in communicating with sensory-impaired veterans.
4. The facility leaders consistently identify opportunities for improvement, ensure staff implement appropriate action plans, and evaluate actions for sustained improvement.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C, D, and E for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Abbreviations

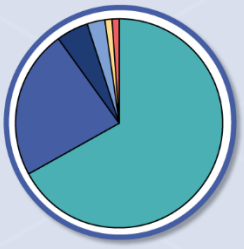
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

Birmingham VA Health Care System
Birmingham, AL
Level 1b-High Complexity Facility
Jefferson County
Hospital Referral Region: Birmingham

Description of Community

RACE AND ETHNICITY



MEDIAN INCOME

$46,667

EDUCATION

83% Completed High School
53% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **317**

POPULATION

Female **1,766,035**
Veteran Female **25,212**
Male **1,657,772**
Veteran Male **198,786**

Homeless - State **3,752**
Homeless Veteran -State **308**

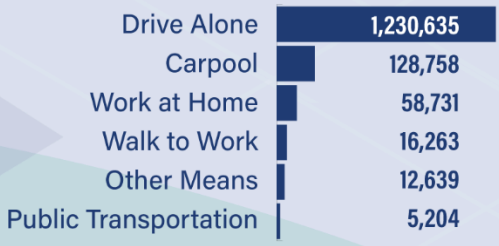
UNEMPLOYMENT RATE

3% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

SUBSTANCE USE

26.8% Driving Deaths Involving Alcohol
15.2% Excessive Drinking
905 Drug Overdose Deaths

TRANSPORTATION



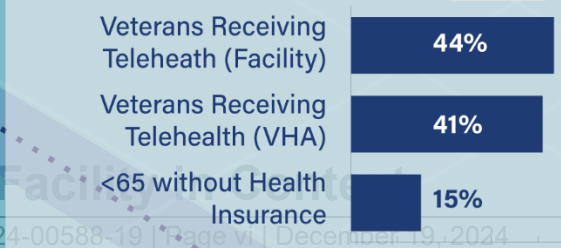
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**33.5 Minutes, 29 Miles**
Specialty Care	**67 Minutes, 67 Miles**
Tertiary Care	**89 Minutes, 91 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 27,410



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

23,395

158 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.79 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
20	35

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	72,229
Unique Patients VA Care	68,511
Unique Patients Non-VA Care	30,783

VA MEDICAL CENTER VETERAN POPULATION

403 — 40,632

COMMUNITY CARE COSTS

Unique Patient $20,816	Outpatient Visit $295
Line Item $479	Bed Day of Care $308

STAFF RETENTION

Onboard Employees Stay <1 Yr	14.25%
Facility Total Loss Rate	10.12%
Facility Retire Rate	1.91%
Facility Quit Rate	7.34%
Facility Termination Rate	0.64%

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, https://www.va.gov/health/aboutvha.

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]

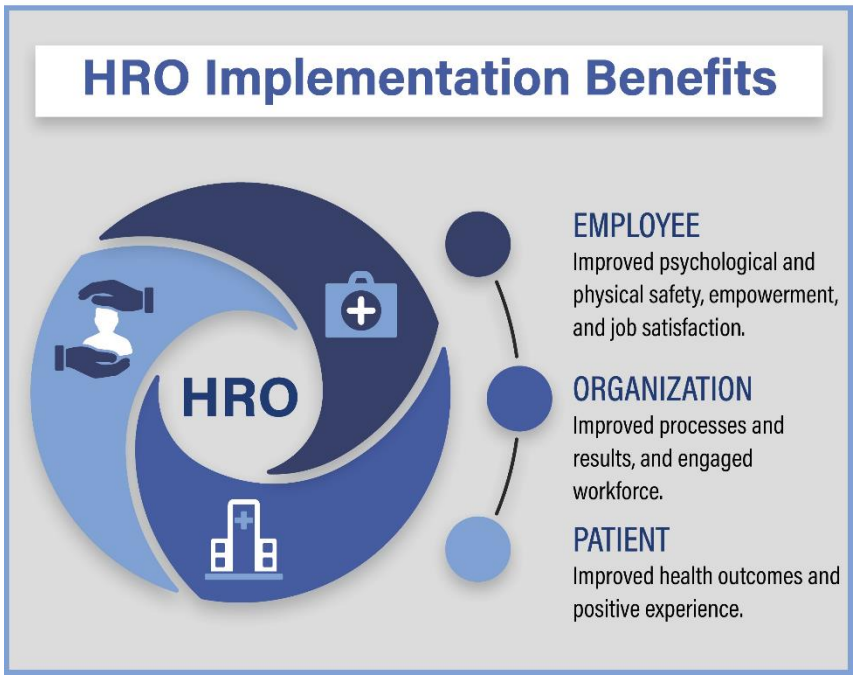


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of

[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.)

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 Birmingham VA Health Care System opened in 1953 and is 1 of 7 VA medical facilities that performs kidney transplants and 1 of 13 that offers a Blind Rehabilitation Center. The facility's executive leaders consisted of an Executive Director (Director), Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The newest member of the leadership team, the Assistant Director, was appointed in February 2022. The Associate Director for Patient Care Services, appointed in June 2013, was the most tenured. In fiscal year (FY) 2023, the facility's budget was approximately $1 billion. The facility had 141 operating beds, including 129 hospital beds.

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."[13] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[14] 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).[15]

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

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

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

[15] 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.

focus and culture.[16] 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.[17] 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 interviews with the OIG, executive leaders discussed two significant system shocks that affected the organization: the COVID-19 pandemic and the unexpected departure of the previous Director approximately three years earlier. The leaders reported that staff faced the pandemic's challenges, emphasizing their relentless efforts, devotion to their work, and kindness and commitment to the patients and each other. In addition, the leaders provided clear communication to frontline staff about the availability of supplies to help overcome their concerns about safety risks during the pandemic. To reduce potential problems after the previous Director left, the remaining executive leaders increased transparent communication and focused on positive messaging and making small improvements in staff's daily experiences, such as eliminating parking charges. Leaders credited their open-door policy to helping minimize the effects of system shocks.

The leadership team discussed several unique attributes of the Birmingham VA Health Care System that have a positive impact on its culture, including the strong affiliate relationship with the University of Alabama at Birmingham, which fosters innovative health care at the facility through staff's access to current research, technology, and clinical services.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[18] 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

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

[17] 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*.

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

culture.[19] 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."[20]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[21] The facility's All Employee Survey scores increased each year. During an interview, the executive leaders attributed the positive communication scores to producing the Director's weekly newsletter and sharing veterans' compliments with staff. Leaders also described communication as occurring through huddle boards posted throughout the facility (a way to communicate important and timely information to staff), rounds (walks through the facility to observe clinic operations and speak with staff), and daily emails. Leaders added that staff know who they are and engage them in conversations because they feel psychologically safe.[22]

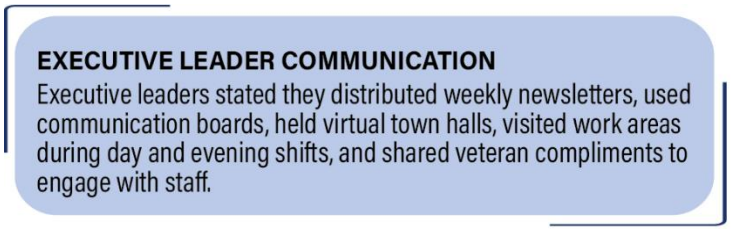


Figure 4. *Leader communication with staff.*
Source: Interview with facility leaders.

Executive leaders shared an example of a barrier to communication with staff who work a night shift. They identified a need to ensure equitable communication and addressed it with initiatives, such as making rounds outside normal business hours and offering virtual town halls and educational opportunities that staff can watch at their convenience.

The OIG found leaders placed a strong focus on communicating with staff. Responses to the OIG questionnaire showed staff agreed that leaders had made changes to how they communicate information, that these changes were an improvement, and that information was clear, useful, and frequent.

[19] 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*.

[20] 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.

[21] 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.

[22] 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.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[23] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[24] 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.[25] 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.[26]

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

The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity. The OIG reviewed VA survey results related to workplace diversity, which included questions about inclusivity, opportunities, and discrimination in the workplace. The OIG noted that workplace diversity scores improved each year from FYs 2021 to 2023. The OIG reviewed documents with examples of multiple diversity-focused events over the last year, such as Black History Month, Pridefest Week, and a recognition of women's contribution to the facility. In addition, the OIG noted the facility met the goal for employing individuals with targeted disabilities. To explain this achievement, leaders highlighted frequent collaboration between the Equal Employment Opportunity Manager and Director; they implemented actions to help

[23] 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.

[24] 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.

[25] Barjinder Singh, Doan Winkel, and T.T. Selvarajan, "Managing Diversity at Work: Does Psychological Safety Hold the Key to Racial Differences in Employee Performance?"; Department of Veterans Affairs, *VHA HRO Framework*.

[26] 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.

employees understand how to self-identify disabilities and worked with human resources staff to approve job listings aimed toward underrepresented groups using special hiring authorities.[27]

Employee Experience

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

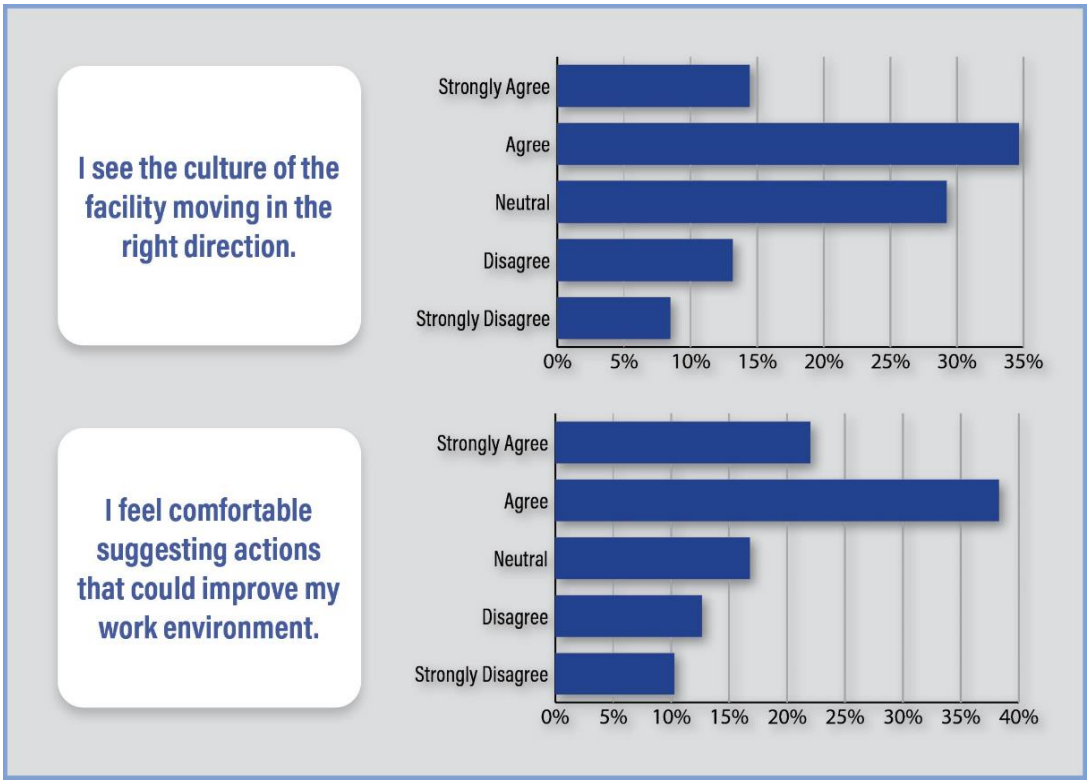


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

[27] Government agencies may use special hiring authorities to target specific segments of the population such as veterans and those with disabilities. "Hiring Authorities," Office of Personnel Management, accessed August 2, 2024, https://www.opm.gov/policy/oversight/hiring-authorities.

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

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

The OIG reviewed survey questions and leaders' interview responses related to psychological safety. VA survey scores related to employees' perceptions about best places to work, no fear of reprisal, supervisor trust, and psychological safety had increased each year from FYs 2021 to 2023. During interviews, executive leaders attributed the increased best places to work score to the new Organizational Health Coordinator and Clinical Wellbeing Officer, who work directly with employees in each department to address areas for improvement. Leaders also stated that fostering psychological safety increases employees' comfort with reporting concerns.

In the OIG-administered questionnaire, most respondents indicated that pay and benefits keep them at the facility and almost half reported the organizational culture was moving in the right direction. Questionnaire responses also revealed stress and burnout as reasons employees would consider leaving. Executive leaders said they were aware of employees' concerns about stress and burnout and had hired over 300 additional full-time employees last year, including a recruiter to help hire physicians, and the Clinical Wellbeing Officer, who offers employees resources to improve aspects of their work and life. In addition, the leaders offered work flexibilities such as telework, compressed schedules, and part-time shifts.

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.[30] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[31] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

During interviews, executive leaders indicated they had positive relationships with local VSOs and other veteran advocacy groups and met regularly with them to share information about veterans' concerns. In response to OIG questionnaires, both VSOs and patient advocates conveyed that there are mechanisms to provide direct feedback to facility leaders, who are responsive to veterans' concerns.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[32] 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: "Birmingham VA Medical Center," Department of Veterans Affairs, accessed May 15, 2024, https://www.va.gov/birmingham-health-care/locations).*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

[32] VHA Directive 1608(1).

[33] 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.

[34] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

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

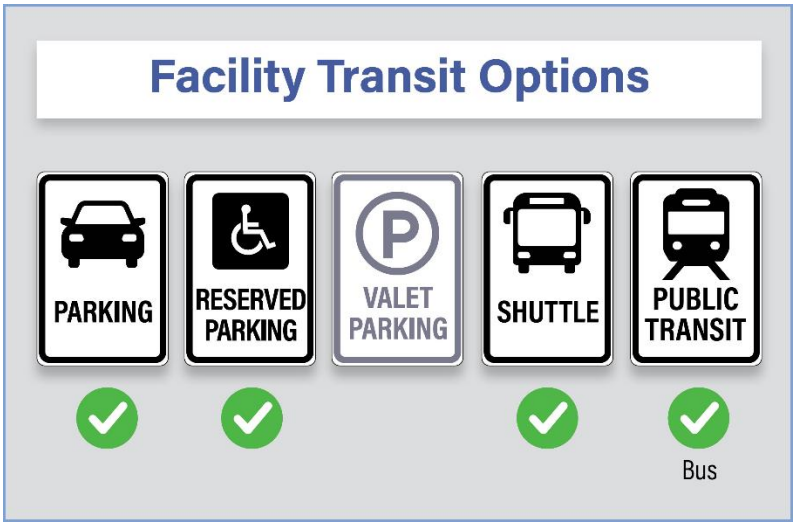


Figure 8. *Transit options for arriving at the facility.*
Source: OIG observation and document review.

The OIG team located the facility in downtown Birmingham and its main entrance using the address listed on the facility's website and signage. Quality management staff informed the OIG that previously, public buses dropped veterans off directly in front of the main entrance; however, due to a city construction project, the nearest public bus stop is now two blocks away and uphill, making it challenging for veterans to get to the facility. The OIG noted the facility did not have attached parking for veterans. The Deputy Associate Director of Patient Services explained that, due to the limited downtown parking, leaders lease an off-site parking garage, and staff provide transportation and parking instructions during new veteran enrollment.

The OIG, along with facility staff, toured the off-site parking garage, which consisted of eight floors, with four floors designated as patient parking. The Chief of Police said that a shuttle service provides 24-hour transportation between the facility and parking garage. The chief added that staff are available 24 hours a day to assist veterans with directions to the shuttle service and they use golf carts to transport those who have difficulty walking.

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.[35]

The area immediately outside the entrance has a large patient loading zone for shuttle services and wheelchairs. The entrance also has a large canopy to shelter veterans from inclement weather, covering wheelchair ramps along both sides. The OIG team entered the facility through power-assisted doors and found an open, well-lit entrance area with natural light throughout.

[35] 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*.

Directly inside the doors, the OIG team observed a staffed information desk. The OIG also noted the entrance had easily accessible assistive devices, such as wheelchairs, and an area with free coffee and seating that would allow veterans to socialize. The OIG found the main entrance to be welcoming and well-kept.

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.[36]

The OIG assessed navigation resources available to veterans, which included a kiosk machine in the entryway and a wayfinding application with directional cues. At the kiosk, veterans could print directions to specific clinic locations. The wayfinding application, which could be downloaded with a smart phone, provided auditory step-by-step directions throughout the facility. However, the OIG observed that floor maps along corridors were not current and created a challenge in navigating the facility. The Chief of Engineering said they were aware of needed improvements in maps and have a plan to address them, pending input from interior design staff.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37]

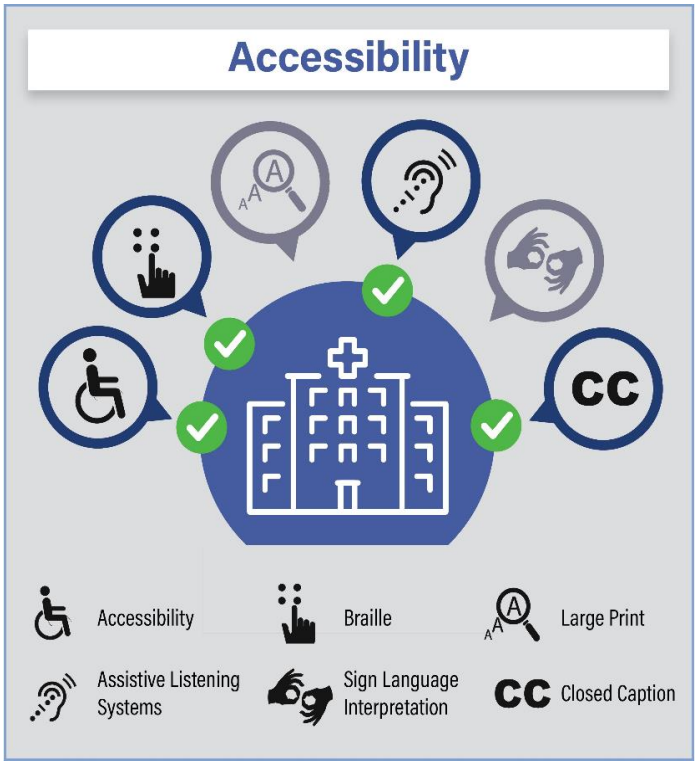


Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations.

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

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

During inspection rounds, the OIG confirmed the availability of braille on signage in halls and elevators. Additionally, the OIG observed navigation resources for veterans with vision impairments, which included detectable changes in flooring for use with canes and automatic front doors. However, the OIG found the small font size used on signage could be challenging for some veterans to read. The Chief of Engineering stated the font size was chosen so all facility locations could fit on one sign. The chief added that staff submitted a work order for interior design staff to replace the signs and enlarge the font, with expected completion in about four months.

The OIG also noticed acoustic tiles present throughout the halls, waiting areas, and exam rooms that assist veterans with hearing impairments by absorbing sound and reducing noise. The OIG noted that front desk personnel provided veterans with directions and assistive devices when needed. However, when the OIG asked front desk personnel how they assist sensory-impaired veterans, they were unable to verbalize a process and stated they had not received training. The OIG recommends that executive leaders ensure front desk personnel are competent in communicating 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.[38]

The Toxic Exposure Screening Coordinator explained that two nurse navigators screen veterans during primary care, specialty care, and walk-in appointments; and a new work group with five nurse practitioners offer walk-in screenings for veterans who need them. The coordinator stated that the navigators' role includes identifying veterans who have not been screened and notifying providers to complete the screening. The coordinator also confirmed that navigators can screen veterans by phone, and they had developed newsletters and handouts to make veterans aware of available screening services. During inspection rounds, the OIG observed handouts containing toxic exposure screening information at the front desk and check-in locations.

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.[39] The OIG analyzed facility

[38] 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.

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

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

The Chief, Safety and Occupational Health stated the Comprehensive Environment of Care team inspects clinical areas biannually and administrative areas annually. Although the team created a multidisciplinary team to identify improvement opportunities, the OIG identified repeat findings from an FY 2020 OIG inspection.

VHA requires Veterans Integrated Service Network (VISN) leaders to ensure facilities within their network are clean and safe.[40] The OIG found clean and soiled linen stored together in the Medical Surgical Unit's storage room. In the Surgical Intensive Care Unit's biohazard room, the OIG found clean linen bags stored with soiled items, including biohazard equipment, and unit staff stated this has been the usual practice. The OIG also found clean and dirty equipment and supplies stored together during an FY 2020 OIG inspection and recommends VISN leaders ensure facility staff separate them to prevent cross-contamination.[41]

The OIG also identified a trend of general uncleanliness throughout the facility, which included dust and torn surfaces on equipment and furnishings in inpatient rooms and inpatient and outpatient waiting room areas. During an interview with the Comprehensive Environment of Care Chair, the OIG asked about facility-identified barriers to maintaining expected cleanliness. The chair attributed the problems with maintaining cleanliness, in part, to staffing shortages in the Environmental Management Service. The chair added that facility leaders were aware of staffing shortages and planned to expedite the recruitment process. Of note, the OIG found trends of general uncleanliness during an FY 2020 OIG inspection and recommends VISN leaders ensure facility staff keep the environment clean and safe.[42]

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 and outpatient settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG physically inspected five units: the Medical Surgical Unit, Surgical Intensive Care Unit, Palliative Care Unit, Primary Care Clinic, and Emergency Department. The OIG found

[40] VHA Directive 1608(1). VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Services Networks (VISNs)," Department of Veterans Affairs, accessed August 29, 2024, https://www.va.gov/HEALTH/visns.asp.

[41] VA OIG, *Comprehensive Healthcare Inspection of the Birmingham VA Medical Center in Alabama*, Report No. 20-00130-241, September 10, 2020.

[42] VA OIG, *Comprehensive Healthcare Inspection of the Birmingham VA Medical Center in Alabama*.

stained ceiling tiles in the Medical Surgical Unit, the Palliative Care Unit, and corridors. The OIG also noted water leaks and wall damage in patient restrooms. The Chief, Safety and Occupational Health, who was present during rounds, stated leaders have an action plan to repair the water pipe leaks that caused this damage. The OIG observed additional water damage that resulted in bulging and peeling walls in the Palliative Care Unit's patient waiting area and along the hallways. During the rounds, the Chief of Engineering said the damage was due to leaking windows and provided documentation of a planned $6.6 million project to replace 600 windows throughout the facility. However, the funding had not been released at the time of the OIG inspection.

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.[43] 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.[44] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG noted that scores for the quality measure reflecting communication of abnormal test results trended downward over the previous four quarters. The Quality Management Director shared that staff identified a recent trend showing primary care providers failing to receive patients' test results from Emergency Department visits. This same leader reported believing that a pending facility policy revision will clarify communication responsibilities between Emergency Department ordering providers and the primary care providers and that, along with staff education on those changes, would address this concern.

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

[44] 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.

Leaders provided several examples of how quality management staff monitored critical test results, and the communication of results between providers. The Chief of Staff stated facility staff do not consistently monitor abnormal test results and report them to an oversight committee. Further, the Chief of Staff said that providers usually receive view alerts for urgent, noncritical results in the electronic health records and they may suffer from alert fatigue.[45] The Chief of Staff acknowledged not formally surveying providers to confirm that belief but having to make several efforts over the last year to retrospectively address unresolved view alerts. Facility leaders reported they recently created a work group to develop a process to help providers better manage their view alerts in a timely manner. The OIG encourages facility leaders to continue to implement actions to improve timely communication of test results.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[46] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG noted that various committees tracked action plans from previous oversight survey recommendations to ensure staff implemented corrective actions. The Quality Management Director stated that staff compare all new findings from oversight agencies, such as the OIG and Joint Commission, to previous findings to identify possible themes. The leader also confirmed no identified themes were related to communication of test results in the last three years.

The OIG found staff conducted one root cause analysis in FY 2022 after discovering a significant delay in the ordering provider's communication of an urgent, noncritical pathology test result to community providers during a patient's cancer treatment.[47] The OIG noted that, after the analysis, staff implemented corrective action plans such as educating providers on VHA's notification requirements.[48]

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[45] A view alert is an electronic notification in a computerized patient record system designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, Office of Information and Technology (OIT), *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, December 2023. View alert fatigue occurs when clinical staff become desensitized to these alerts and miss or fail to respond appropriately to information, usually due to the high volume of alerts generated by the system. "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

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

[47] A root cause analysis is a formal, "comprehensive, team-based, systems-level investigation" for reviewing "health care adverse events and close calls." VHA Directive 1050.01(1).

[48] VHA Directive 1088(1).

The OIG reviewed patient safety reports for the twelve months preceding the inspection and identified seven reports that involved delays in communication of test results. Three of those reports included delays in diagnostic providers communicating with ordering providers. Facility leaders said they addressed the causes of those delays with system-wide education that included communication to staff through new employee orientation, huddle boards, emails, committees, and staff meetings. The remaining four reports involved delays in patient notification, and staff subsequently reminded primary care providers during a department meeting about the expectations for communicating test results to patients in a timely manner.

Additionally, the OIG found that staff communicated patient safety event data monthly in several committees but did not evaluate common safety themes. Leaders reported they had several vacancies for a patient safety manager and other quality management staff over the last two years, which made it difficult to evaluate patient safety themes and confirm staff completed corrective actions. Leaders said the quality management department had increased staffing levels, current processes were not dependent on an individual, and staff report open actions monthly for leaders' oversight.

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.[49] 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.[50] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Leaders described a routine process of repeatedly evaluating improvement plans and addressing barriers, adjusting actions, and ultimately involving VISN leaders to improve quality measures. The OIG found that staff used several databases to track and report numerous quality measures. Some of those measures, such as communication of mammogram results to patients, demonstrated sustained improvement after staff implemented action plans. However, measures for communication of certain telemedicine test results to patients had not improved.[51]

Leaders stated that oversight committees had worked to ensure communication about performance improvement (quality measure goals, compliance rates, and practice changes) flows to and from staff through committees, department meetings, and emails. The OIG observed that,

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

[50] VHA Directive 1050.01(1).

[51] "Telemedicine is the use of electronic information and communications technologies to provide and support health care when distance separates the participants." Institute of Medicine, "Introduction and Background," in *Telemedicine: A Guide to Assessing Telecommunications in Health Care*, ed. Marilyn J. Field (Washington, DC: The National Academies Press, 1996), 16.

despite leaders regularly discussing communication of test result measures within oversight committee meetings, staff had not implemented action plans to address some deficient measures, such as communication of telemedicine eye examination results to patients with diabetes. Leaders reported being aware of this issue and said they recently updated one of the oversight committee agendas to prompt a more detailed discussion of the measures and progress on any associated action plans. They also planned to update the agendas for all oversight committees.

A leader stated that improved oversight committee involvement resulted from increased staffing and new executive and quality management leaders over the past several years. The leader added that the quality management department is now stable and moving forward in a proactive manner. The OIG recommends that facility leaders consistently identify opportunities for improvement, ensure staff implement appropriate action plans, and evaluate actions for sustained improvement.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[52] 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.[53] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[54] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG found the facility had some physician and medical support staff position vacancies; however, primary care team members reported the vacancies had minimal effect on workflows. Primary care leaders stated they focus on recruitment and retention and that some potential candidates accepted positions outside VA because of its lengthy and complex hiring process.

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[52] 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.

[53] 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).

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

Leaders said the new physician recruiter helps new hires move through the process more efficiently and attends conferences and meets with local residents and medical students at the University of Alabama at Birmingham to recruit potential applicants.

In addition, primary care team members and leaders described taking steps to improve recruitment and retention for non-physician positions. For example, primary care leaders reported developing a partnership with the local nurse practitioner residency programs to facilitate recruitment of new staff. To improve retention, executive leaders supported pay increases for medical support staff and worked with the Clinical Wellbeing Officer to reduce employee burnout.

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.[55] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[56]

VHA expects each primary care team panel to have a baseline capacity of 1,200 patients.[57] The OIG found that panel sizes had remained consistent and did not exceed the expected capacity over the previous two FYs. Despite panel sizes remaining consistent, staff informed the OIG that their patient population is aging with increasingly complex needs, requiring providers to spend more time managing their care. Although other clinicians, such as pharmacists and nurses, support the primary care teams in managing patients with complex needs, staff said they felt their workload was increasing but remained manageable. Team members also shared that facility leaders have addressed their increasing workload to mitigate potential frustration and burnout through efforts like piloting the use of virtual work for some staff.

According to primary care team leaders, the Patient Aligned Care Team Coordinator communicates regularly with teams to assess their needs and manage panel sizes. The coordinator reported presenting primary care efficiency data during the facility's morning meeting to keep leaders aware of issues affecting operations.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] Continuous process improvement is also one of the three

[55] "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).

[56] VHA Directive 1406(1).

[57] VHA Directive 1406(1).

[58] VHA Handbook 1101.10(2).

HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care team members and leaders both reported frequently identifying opportunities to improve the teams' efficiency. Team members explained that facility leaders have assisted teams in improving efficiency by

- hiring more registered nurses to assist with patient care,
- providing physicians and pharmacists with time to perform administrative tasks,
- increasing telework options,
- advocating for providers to complete video visits instead of in-person visits when appropriate, and
- hiring more medical support staff to improve scheduling processes.

Primary care team members shared several examples of ongoing employee-driven process improvement projects, such as allowing the patients' healthcare goals to determine the focus of primary care visits and standardizing the orientation process for registered nurses. Primary care leaders reported working with an analyst to assist staff in understanding data to guide process improvement projects. The leaders added they update facility leaders monthly on current process improvement projects during the Primary Care Operations meeting.

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 experienced an increase in veteran enrollment from FY 2021 through August 2023. Primary care team members and leaders shared that veteran enrollment will likely continue to increase, which may affect appointment wait times. Additionally, primary care team members said the new toxic exposure screening requirement increases workload and the time from the patient's point of intake with nursing staff to when they see the provider.

A primary care provider stated that scheduling is the key to their success in managing wait times, and that medical support staff schedule patients based on provider availability. For example, primary care staff said that, even though a new patient is assigned a provider, support staff may schedule the initial appointment with a different provider who has earlier availability to ensure timely access to care. Additionally, primary care staff reported establishing clinics with same-day access so established patients can see a provider without an appointment.

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.[59]

Identification and Enrollment of Veterans

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

HCHV staff reported that social workers identify veterans who are homeless or at risk of becoming homeless and refer them to the program. Staff also said they have outreach social workers who identify homeless veterans in the community and refer them to program staff to receive an intake assessment. Staff stated they want to increase collaboration with community partners to help locate unsheltered veterans.

Staff added they want to improve how they document in the system of record. For instance, if staff document that an unsheltered veteran occasionally stays with a relative, the system of record will not show the veteran as unsheltered, which does not accurately capture data for the performance measure.

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

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

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

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).[62]

The program did not meet the performance measure target for veterans discharged from the program into permanent housing in FYs 2021, 2022, or 2023, instead achieving annual measures of 14 percent, 23 percent, and 30 percent, respectively. Program staff said that previously, when unsheltered veterans who are enrolled in the program receive income, staff prematurely discharged them from residential services before ensuring they established permanent housing. However, they no longer discharge veterans immediately after they receive income, which has led to fewer premature discharges from residential services. As a result, the facility's percentage of veterans discharged to permanent housing exceeded VHA's target for FY 2024 through March 26, 2024.

The OIG found the program did not meet the target for veterans discharged due to rule violations for the two most recent FYs. Program staff said the target was difficult to meet because it relies on veterans' behaviors, which are outside of staff's control. For example, community partners may evict veterans who struggle with substance abuse from a residential program for bringing alcohol on the premises.

Figure 10. *Facility's current community partnerships.*
Source: OIG analysis of document.

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

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[63] 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.[64]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[65] The facility met the expected target in FY 2023. Program staff described identifying and enrolling veterans in the Veterans Justice Outreach and Health Care for Reentry Veterans programs through all stages of the criminal justice system, using multiple referral sources such as local jails, courts, law enforcement, attorneys, and community partners. To encourage enrollment, staff said they provide educational handouts to veterans involved in the criminal justice system and to community partners.

As the sole staff member for Health Care for Reentry Veterans program, the coordinator expressed passion for the work, which included outreach and support for incarcerated veterans preparing for release from prison. The coordinator reported being responsible for a geographical area, including all federal prisons in Alabama and 10 prisons in Georgia. The coordinator travels to each prison, meets with incarcerated veterans four to six months before their release, and coordinates with prison wardens and counselors to develop a plan for the services needed after release. The coordinator also provides information to incarcerated veterans about the program, VA healthcare enrollment, and other resources for successful reentry into society.

Meeting Veteran Needs

During an interview, Veterans Justice Outreach staff provided the OIG with information on the facility's Veterans Response Team, which is a partnership with suicide prevention coordinators, mental health and Emergency Department staff, and VA police. The team works to prevent veterans from entering the criminal justice system by offering support to foster psychological stability, addressing medical needs, and assisting with sobriety. Staff described their efforts to ease any self-directed shame among veterans and reduce the stigma associated with the criminal justice system. Staff said they found it rewarding to support veterans and provide them options other than jail.

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

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

[65] 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*.

Staff also told the OIG that leaders were very supportive of the program. Staff added that they appreciated the facility's weekly meetings for program staff, where they shared program successes and concerns, and program leaders expressed their appreciation.

Veterans Justice Outreach staff said they assist veterans in participating in program services and collaborating with community partners to help meet their needs. Staff shared that a veteran needed health care while incarcerated and housing after release, which they helped successfully coordinate with the judicial system and VHA mental health, HCHV, and Housing and Urban Development–Veterans Affairs Supportive Housing program staff. In addition, staff said that some courts offer gift cards for veterans to purchase food, coffee, and gas as incentives for participating in the program.

A veteran located outside the immediate Birmingham area did not have transportation, and leaders approved funding for a taxi. As a result, Veterans Justice Outreach staff expressed feeling supported in their roles to meet veterans' needs.

Figure 11. *Veterans Justice Outreach success story.*
Source: OIG interviews.

The Health Care for Reentry Veterans Coordinator discussed meeting veterans' needs through collaboration with Veterans Justice Outreach staff and community partners, such as county law enforcement agencies, probation services, the local Social Security Administration office, and VA housing assistance staff. The coordinator shared a success story about a former program participant who now owns and operates a business.

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."[66] 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.[67]

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

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).[68]

The OIG noted that program staff had met the performance measure target in FYs 2021 to 2023. Program staff said, despite this success, limited affordable housing options and landlords' unwillingness to participate in the program remains a concern. Program staff reported meeting weekly with public housing staff to keep them updated on the number of vouchers available and the number of veterans discharged and housed. In addition, program staff described having 42 landlords participate in an annual engagement event held by the facility and a community partner to share information about the program and encourage landlords' participation.

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).[69] The facility's performance measure data showed the program consistently met VHA's target from FYs 2021 to 2023. Program staff attributed this success to having an employment specialist who networks with potential employers in the area. In addition, staff reported tracking veterans' employment status to identify those requiring assistance.

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.

[68] 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*.

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

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 clean and soiled linen stored together in a storage room, and clean linen bags stored with soiled items, including biohazard equipment, in a biohazard room. This is a repeat finding from an FY 2020 OIG inspection.

Recommendation 1: The OIG recommends that Veterans Integrated Service Network leaders ensure facility staff separate clean and dirty equipment and supplies to prevent cross-contamination.

Major

Finding: The OIG found that facility staff did not consistently provide a clean and safe environment for patients, visitors, and staff. The OIG observed dust and torn surfaces on equipment and furnishings in inpatient rooms and inpatient and outpatient waiting room areas. This is a repeat finding from an FY 2020 OIG inspection.

Recommendation 2: The OIG recommends Veterans Integrated Service Network leaders ensure facility staff keep the environment clean and safe.

Finding: The OIG noted that front desk personnel provided veterans with directions and assistive devices when needed. However, they were unable to verbalize a process for assisting sensory-impaired veterans and stated they had not received training.

Recommendation 3: The OIG recommends that executive leaders ensure front desk personnel are competent in communicating with sensory-impaired veterans.

Finding: The OIG noted that although facility leaders were aware of low-performing measures related to the communication of test results, they did not ensure staff implemented action plans for improvement for some of the deficient measures.

Recommendation 4: The OIG recommends that facility leaders consistently identify opportunities for improvement, ensure staff implement appropriate action plans, and evaluate actions for sustained improvement.

Appendix A: Methodology

Inspection Processes

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from March 11 through 14, 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 OIG reviewed All Employee Survey results for FYs 2020, through 2023; the VA OIG, *Comprehensive Healthcare Inspection of the Birmingham VA Medical Center in Alabama* report; and results from The Joint Commission's hospital accreditation review for August 2022 and laboratory accreditation review for September 2022.

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

Category	Metric	Metric Definition
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented 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 18, 2024

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama

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

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

1. Thank you for the opportunity to review and comment on the draft report regarding the Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama.
2. I concur with the recommendations and action plan submitted by the Birmingham VA Health Care System for recommendations 3, and 4. In addition, I concur with VISN 7's action plan for recommendations 1 and 2.
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 the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA, FACHE
Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 25, 2024

From: Director, Birmingham VA Health Care System (521/00)

Subj: Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama

To: Director, VA Southeast Network, VISN 7 (10N7)

1. Thank you for the opportunity to review and comment on the draft report regarding Healthcare Facility Inspection of the Birmingham VA Health Care System in Alabama. The Birmingham VA Health Care System makes patient care and safety a priority and we appreciate the Office of the Inspector General's partnership in our continuous improvement efforts for our Veterans.
2. I have reviewed and concur with the recommendations and provided action plans in the attachment.
3. Comments regarding the contents of this memorandum may be directed to the Director of Quality and Patient Safety.

(Original signed by:)

Oladipo Kukoyi, MD, MS, VHA-CM
Director, Birmingham VA Health Care System

Appendix E: VA Responses

Recommendation 1

The OIG recommends that Veterans Integrated Service Network leaders ensure facility staff separate clean and dirty equipment and supplies to prevent cross-contamination.

_X_ Concur

____ Nonconcur

Target date for completion: July 2025

Director Comments

The prior Environment of Care (EOC) rounding audit tool was updated on November 6, 2024, to ensure monitoring of clean and soiled utility rooms for potential cross-contamination. In addition, the process of rounding was strengthened by the implementation of a monthly after-hours EOC rounding team on May 23, 2024. This team will provide oversight by utilizing the updated rounding tool, effective November 21, 2024, to track and monitor EOC findings and address facility safety and environmental issues. The Associate Director is a part of the after-hours EOC team. Other members of the team consist of Environmental Management, Biomedical Engineering, Engineering, Infection Control, Hospital Safety, and Quality Management. Each month, EOC compliance audits will be completed by the after-hours rounding team. A total of ten utility rooms, denominator, (5 clean utility rooms and 5 soiled utility rooms) will be assessed by the after-hours EOC rounding team, for placement of clean and soiled items in the correct utility room location, numerator. EOC compliance audits will be reported monthly by the Quality Management Director, with any summarized actions to the facility Quality Patient Safety Council where the Medical Center Director is the Chair. The Quality Management Director will begin reporting December 9, 2024, and will continue until 90 percent compliance is achieved and maintained for six consecutive months. The facility Quality Management Director will report monthly compliance results and summarized actions to the VISN 7 Quality Patient Safety Council for Network Director oversight until 90 percent compliance is achieved and maintained 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 Veterans Integrated Service Network leaders ensure facility staff keep the environment clean and safe.

_X_ Concur

____ Nonconcur

Target date for completion: July 2025

Director Comments

The Co-Chair of the Safety and Environment of Care Committee revised service level environment of care checklists for inpatient units and outpatient clinics to specifically state furniture must be assessed for wear and tear on November 6, 2024. The modified checklist includes an assessment of overall cleanliness, condition of furniture, and storage of clean and soiled equipment. Effective November 21, 2024, the afterhours Environment of Care team will assess a total of ten patient care areas, denominator, for torn furniture and cleanliness issues.

Verification of torn furniture removal and resolution of cleanliness issues will be accomplished through visual confirmation by the facility Accreditation Manager through documentation on the environment of care checklist. The numerator will be the number of areas where 100% of corrections of torn furnishings and cleanliness issues have been addressed within four weeks. Monthly compliance will be presented by the facility Quality Management Director in Quality Patient Safety Council for facility Director oversight until 90 percent compliance is achieved and sustained for six consecutive months and the Quality Management Director will report the results and action plans to Veterans Integrated Service Network 7 Quality Patient Safety Council for Veterans Integrated Service Network 7 Network Director oversight until 90 percent compliance is achieved and maintained 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 front desk personnel are competent in communicating with sensory-impaired veterans.

_X_ Concur

____ Nonconcur

Target date for completion: May 2025

Director Comments

In February 2024, the Chief of the Veteran Experience and Community Inclusion Service posted sensory impairment posters at the front desk and welcome center and provided front desk staff

with a directory of facility points of contact to assist Veterans and visitors with sensory impairments on March 12, 2024. The Chief of the Blind Rehabilitation Service, in coordination with the Equal Employment Opportunity Manager, will develop a resource document which includes instructions for assisting sensory-impaired Veterans and visitors by December 5, 2024, and will place the document at each front desk. The Chief of Blind Rehabilitation and the Equal Employment Opportunity Manager will provide face to face and /or TEAMS training on the use of the document to current front desk and welcome center staff, denominator, by January 31, 2025, for immediate implementation. Staff attendance, numerator, will be captured via sign-in and /or Microsoft Teams attendance roster and reported by the Chief of Blind Rehabilitation to the Chief of the Veteran Experience and Community Inclusion Service. The Chief of the Veteran Experience and Community Inclusion Service will provide face to face training on the resource document to new staff, denominator, within 60 days of hire and attendance by new staff, numerator, will be capture by sign-in roster. Completion of training to current and new staff will be reported by the Chief of the Veteran and Community Inclusion Service to Quality Patient Safety Council for Executive Director oversight starting in February 2025 and will continue monthly until 90 percent compliance is achieved and maintained for six consecutive months.

OIG Comments

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

Recommendation 4

The OIG recommends that facility leaders consistently identify opportunities for improvement, ensure staff implement appropriate action plans, and evaluate actions for sustained improvement.

_X_ Concur

____ Nonconcur

Target date for completion: May 2025

Director Comments

The facility medical center policy has been updated to include the timely reporting of emergent, urgent, not imminently life-threatening, clinically significant, and normal results and was communicated to staff for implementation August 8, 2024. The policy is pending final signature and will be completed by November 30, 2024. Each month the Chief of Business Intelligence or designee will pull forty patients and give to External Peer Review Program Coordinator for random selection of thirty abnormal reports. Each month thirty random charts, denominator, are being manually reviewed by the External Peer Review Program Coordinator to ensure that abnormal laboratory, pathology, and radiology results that require action have been

communicated to the patient in the appropriate timeframes, numerator. The External Peer Review Program Coordinator will begin reporting monthly trends, action plans, and the percent compliant to Quality Patient Safety Council, where the Medical Center Director is Chair, starting November 2024. The Quality Patient Safety Council will evaluate sustained improvement by monitoring trends until 90 percent compliance is achieved and maintained for six consecutive months.

OIG Comments

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Tamara White, BSN, RN, Team Leader Kelley Brendler-Hall, MSN, RN Patricia Calvin, MBA, RN Latoya Clark, MHA, RD Angela Enlow, PhD Catherine McNeal-Jones, MSN, RN
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Brandon LeFlore-Nemeth, MBA Amy McCarthy, JD Scott McGrath, BS Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS Dave Vibe, MBA

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