US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Northport Healthcare System in New York

Healthcare Facility Inspection	24-00589-17	December 11, 2024

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Northport Healthcare System from April 16 through April 18, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. The OIG found that leaders successfully navigated challenges posed by the COVID-19 pandemic and multiple major construction projects while maintaining care for veterans. The OIG's review highlighted increased workforce diversity over the past three years but noted underrepresentation of certain demographic groups. Leaders discussed various outreach efforts to increase diversity. For instance, the facility had a decrease in veteran employees, and therefore, leaders held veteran-focused job fairs and posted job announcements in patient care waiting areas to encourage veterans to apply.

The OIG also found that employees were generally satisfied with the organization. However, based on the OIG-administered questionnaire, employees identified stress and burnout as the primary reasons they would consider leaving employment. The leaders addressed employees' concerns about stress and burnout by providing access to yoga, tai chi, and an on-site gymnasium

[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.

and childcare center. Leaders also responded to veterans' concerns through designated points of contact and collaboration with veterans service organizations.

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 facility was undergoing multiple construction projects, but staff effectively managed the impact through communication and signage. The facility also had multiple accessibility options for sensory-impaired veterans; however, the OIG identified potential difficulties for veterans with sensory impairments when using kiosks in the main lobby. The kiosks had an audio function that required headphones so veterans could hear check-in directions, but there were no headphones available. Additionally, the patient support representative and a facility leader stated they did not know how to use the kiosks' accessibility feature.

The OIG also observed a clean healthcare environment but noted safety issues in the Emergency Department. The OIG found multiple open cabinets containing medications and supplies, and an injectable medication and syringe that was unattended in an unsecured area. The Nurse Manager attributed it to working in a temporary location pending construction of the new Emergency Department. Overall, while the facility demonstrated positive initiatives, leaders needed to maintain efforts to address identified deficiencies and enhance the overall quality of care provided. The OIG made two recommendations.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found facility staff effectively managed communication of urgent test results to providers through established processes and electronic notifications. The facility did not have open recommendations from previous reports. Leaders employed various review processes to identify opportunities for improvement and were committed to continuous learning, as evident by the 71 process improvement projects in process at the facility.

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.[2] Primary care leaders reported several vacancies during the previous 12 months. However, during the week of the inspection, the leaders reported only four clinical vacancies, with candidates selected for each position. The Chief of Primary Care discussed physician recruitment challenges, including competition with private sector salaries, and therefore emphasized VA incentives to help with recruitment.

Primary care leaders ensured equitable workload distribution and efficient care delivery through collaborative efforts and innovative solutions like adjusting appointment times. Facility leaders remained proactive in addressing staffing concerns, maintaining reasonable panel sizes, and mitigating provider burnout.

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 to assess how well the programs meet veterans' needs. The OIG found staff effectively identified and enrolled veterans into housing programs. Housing and Urban Development–Veterans Affairs Supportive Housing program staff successfully addressed veterans' housing needs but encountered challenges meeting performance targets due to limited available housing, payment standards below typical housing costs, and a higher demand for vouchers than the facility's allotment. To address the challenges, staff established an internal task force that formed connections with a local board of realtors, and the program's housing specialist identified new landlords willing to accept housing vouchers. A program staff member stated that during 2022, the payment standard for a one-bedroom apartment increased, and staff planned to request additional vouchers in the upcoming reallocation request from the VA national program office.

What the OIG Recommended

The OIG made two recommendations.

1. Facility leaders ensure staff secure all medications and the supplies used to administer medications in the Emergency Department.
2. Facility leaders confirm staff are knowledgeable about how the lobby kiosks function to assist veterans with sensory impairments.

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

VA Comments and OIG Response

The Veterans Integrated 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 until they are completed.

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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
VSO	veterans service organization

FACILITY IN CONTEXT

VA Northport Healthcare System
Northport, New York
Level 1c-High Complexity Facility
Suffolk County
Hospital Referral Region: East Long Island

Description of Community

RACE AND ETHNICITY

MEDIAN INCOME

$93,966

EDUCATION

87% Completed High School
69% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **365**

POPULATION

Female **3,922,448**
Male **3,667,914**
Veteran Female **15,931**
Veteran Male **161,695**

Homeless - State **74,178**
Homeless Veteran - State **990**

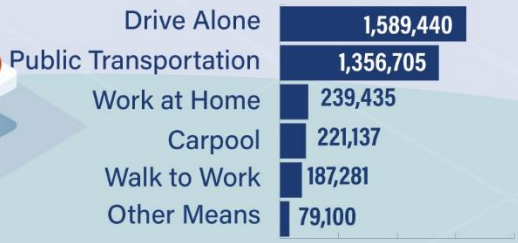
UNEMPLOYMENT RATE

7% Unemployed Rate 16+
5% % Veterans Unemployed in Civilian Work Force

SUBSTANCE USE

16.9% % Driving Deaths Involving Alcohol
19.3% % Excessive Drinking
1,968 Drug Overdose Deaths

TRANSPORTATION



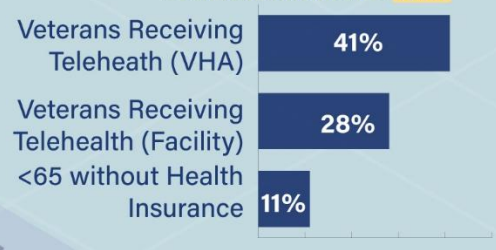
AVERAGE DRIVE CLOSEST TO VA

Primary Care **13 Minutes, 5.5 Miles**
Specialty Care **25 Minutes, 16 Miles**
Tertiary Care **31 Minutes, 19.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **7,117**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

7,808

122 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.59 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

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

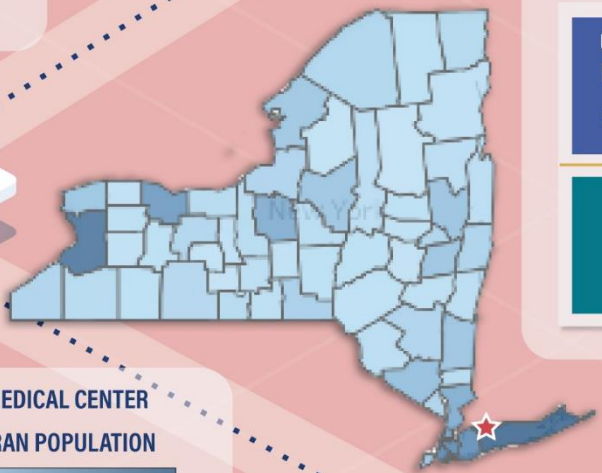
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	28K
Unique Patients VA Care	27K
Unique Patients Non-VA Care	8K

COMMUNITY CARE COSTS

Unique Patient $7,889	Outpatient Visit $398
Line Item $92	Bed Day of Care N/A



STAFF RETENTION

Onboard Employees Stay <1 Yr	11.63%
Facility Total Loss Rate	9.96%
Facility Quit Rate	6.19%
Facility Retire Rate	2.68%
Facility Termination Rate	0.99%

★ VA MEDICAL CENTER

VETERAN POPULATION

466 — 56,446

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

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

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

High Reliability Organization Framework

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

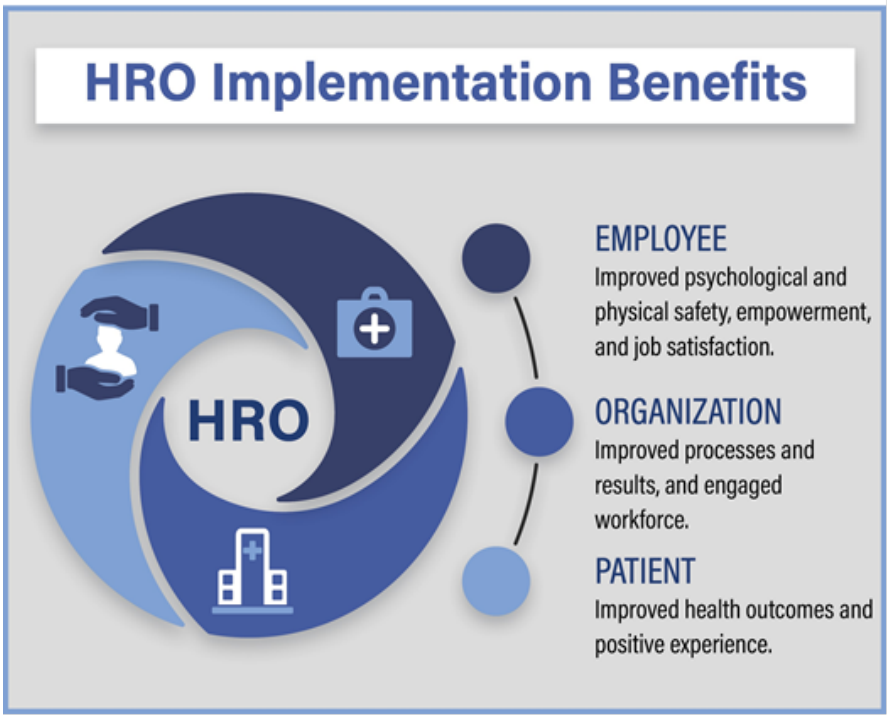


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

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

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

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

Content Domains

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

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

The VA Northport Healthcare System (facility) was first established in the 1920s, and the main patient care facility was constructed in 1972. At the time of the inspection, the facility's executive leaders consisted of a Director, Assistant Medical Center Director, Chief of Staff, Associate Director of Patient Care Services and Nurse Executive, and Associate Director. The associate director of patient care services and nurse executive position was vacant. The newest member of the leadership team, the Assistant Medical Center Director, was assigned in August 2023, and the Director and Chief of Staff had served in their roles since 2019. In fiscal year (FY) 2023, the facility's medical care budget was approximately $540 million. The facility had 338 operating beds, which included 130 hospital beds, 170 community living center beds, and 38 domiciliary beds.[13]

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

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

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

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

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

System Shocks

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

Facility leaders informed the OIG of challenges presented by the COVID-19 pandemic. Although the facility faced supply chain shortages and functioned without backup from the overwhelmed regional healthcare system, leaders described using virtual capabilities that gave veterans more options in scheduling appointments and allowed for safe distancing. Leaders also shared their appreciation of the staff's flexibility and ability to work together throughout the pandemic.

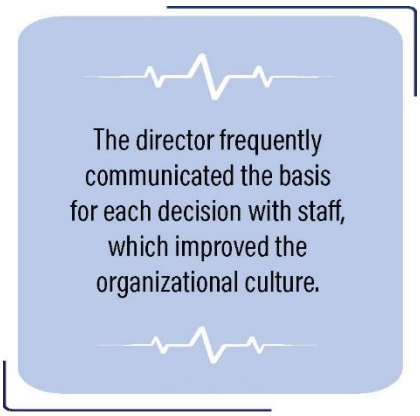


Figure 4. *Leader communication. Source: OIG interviews.*

The OIG noted a planned shock when leaders described undertaking major construction projects, which included constructing a new Intensive Care Unit and renovating several additional areas:

- Emergency Department, including roadways and parking lots in front of the main entrance
- Operating room suite
- Dialysis Department
- Sterile Processing Department
- Patient and freight elevators in multiple buildings
- Fire and smoke doors
- Roofs on multiple buildings

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

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

Despite the magnitude of the construction projects, leaders said the projects had no negative impact on daily operations due to diligent planning and communication with staff and veterans. Leaders anticipated that ongoing construction projects would limit parking and had reviewed options to decrease disruptions in parking and traffic, including adding a valet service. The Director reported posting the information on social media and sharing it at VSO meetings, ensuring stakeholders remain informed about ongoing developments.

The OIG found the facility experienced system shocks, which included multiple, major construction projects. Despite these hurdles, leaders remained committed to providing care for veterans. The OIG made no recommendations.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[19] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[20] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[21] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[22]

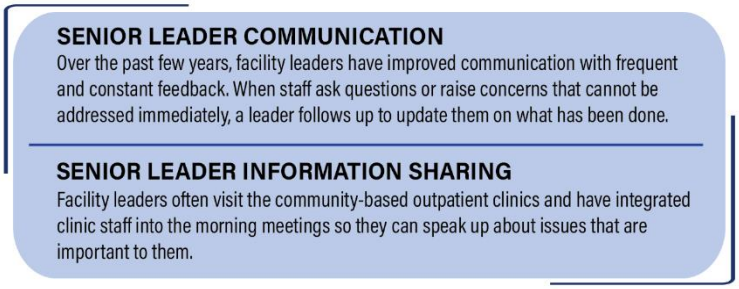


Figure 5. *Leader communication with staff.*
Source: OIG interview with facility leaders.

The OIG found that survey scores increased for clear communication between facility leaders and staff over the past three years. In interviews, leaders emphasized the importance of communicating with staff and highlighted several avenues implemented for this purpose, which included town halls, morning report meetings, emails, and visits to clinics and departments. The Director reported that leaders visit departments to give staff an opportunity to

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

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

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

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

raise issues. The Chief of Staff added that quality management staff document the issues raised and ensure staff receive communication about the resolutions. The acting Associate Director of Patient Care Services and Nurse Executive also informed the OIG that any staff member was welcome to attend the morning report meeting and raise concerns directly to leaders. The OIG determined that facility leaders had taken actions to enhance communication and made no recommendations.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[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] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.

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

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

[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.

All Employee Survey results indicated an improvement in diversity over the past three years. However, after examining the facility's workforce diversity data compared to local community data, the OIG noted a lower-than-expected representation of Hispanic males and females, and White males. The Equal Employment Opportunity Manager reported coordinating with human resources staff to participate in outreach events at colleges and job fairs.

The OIG also noted a decrease in the number of veteran employees and an increase in the number of employees with targeted disabilities over the last five quarters. When asked about hiring practices for these employee groups, the Assistant Director said the facility had organized a veteran-focused job fair to encourage more applicants. The leaders reported that they posted job announcements for veterans in patient care waiting areas and distributed them in the community through the Public Affairs office. The Equal Employment Opportunity Manager found that some employees were reluctant to self-identify their disability but conveyed efforts to assist employees during orientation. The OIG encourages leaders to continue outreach efforts aimed at creating a more diverse workforce. The OIG made no recommendations.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

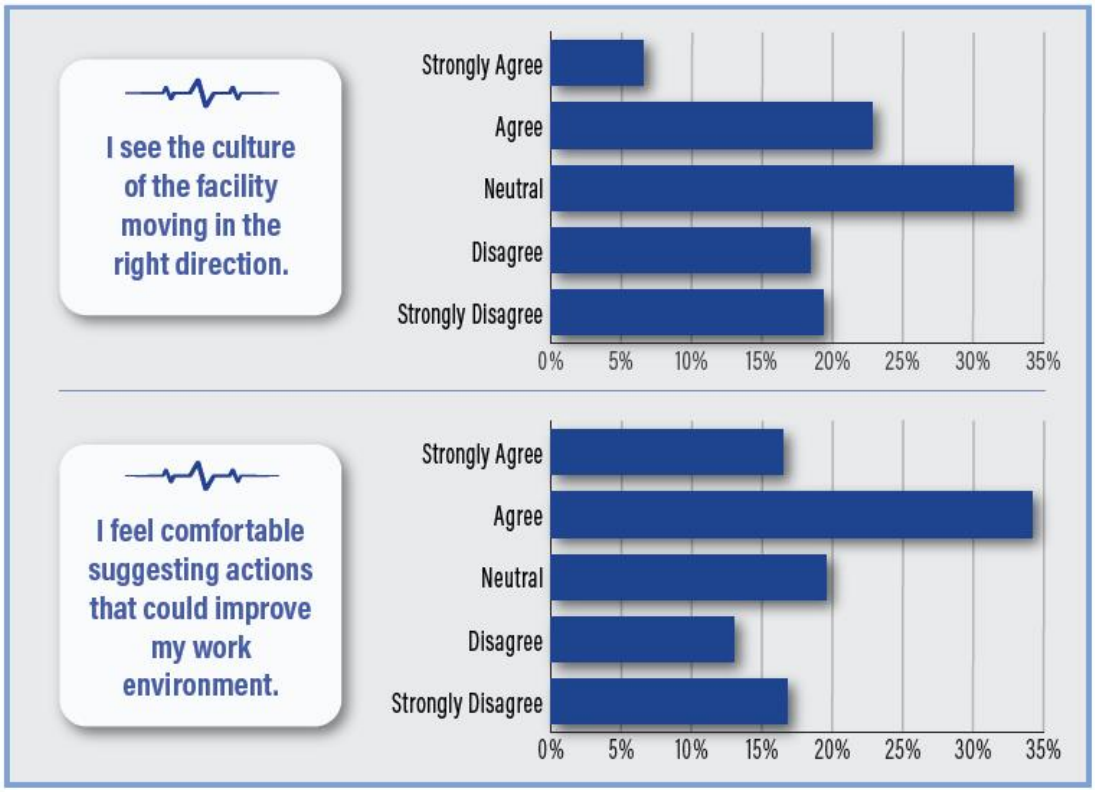


Figure 7. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

The Director described using the All Employee Survey to gauge employee satisfaction. The Director also reported that staff wanted to be heard, as evidenced by the response rate for the survey, which had increased from 71 percent in 2022 to 82 percent in 2023. The Director attributed the increased response rate to leaders engaging staff in process improvements related to the survey results.

[27] 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.

[28] 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 analyzed All Employee Survey scores and found that employees were generally satisfied working at the facility. The scores for supervisor trust, no fear of reprisal, and best places to work steadily increased over the previous three years.[29] In interviews, leaders attributed the rising scores to being approachable and honest, which instilled trust among employees and fostered a positive environment.

Additionally, leaders discussed the importance of recognizing employees for their achievements during morning report meetings and at various activities, including Nurses' Week and Physical Therapy Week. The Director mentioned presenting employees with personally signed certificates of appreciation, believing they perceived them as meaningful recognition.

Respondents to the OIG's questionnaire identified stress and burnout as the primary reasons they would consider leaving employment; however, leaders said they believed stress and burnout are inherent to working in health care.[30] The Director emphasized the importance of employees communicating concerns in real time, and leaders validating those concerns. Facility leaders discussed activities to help manage employees' stress, such as providing access to yoga, tai chi, and an on-site gymnasium and childcare center.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The OIG found the All Employee Survey scores for psychological safety had also increased over the past three years. In interviews, the Director stressed the importance of employees raising concerns to leaders, and the acting Associate Director of Patient Care Services and Nurse Executive said leaders encouraged them to discuss concerns with any leader rather than only follow their chain of command. The leaders said they felt employees were committed to the mission of caring for veterans. The OIG-administered questionnaire validated employees' commitment: the most common response to the question "What keeps you at this organization?" was the VA mission.

The OIG found facility leaders were committed to improving the employee experience. The OIG also found that employees were generally satisfied with the organization and felt psychologically safe raising concerns to leaders. The OIG made no recommendations.

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

[30] The VA Northport Healthcare System had 1,935 employees, and 316 of them responded to the OIG questionnaire.

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.[31] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[32] The OIG reviewed patient advocate reports and a VSO questionnaire to understand veterans' experiences with the facility.

In response to an OIG questionnaire, the Patient Advocate reported that facility leaders were responsive to veterans' concerns. Leaders said that each department at the facility had a designated point of contact to work with the Patient Advocate in addressing veterans' concerns.

The VSO questionnaire responses supported that leaders were responsive to concerns brought to their attention. The Director reported meeting monthly with VSO representatives to provide construction updates, address veterans' concerns, and obtain suggestions for improvements at the facility. For example, VSO representatives relayed veterans' safety concerns about a revolving door at the main entrance. The Director described replacing the door with one that included updated safety features. The Chief of Staff added that VSOs advocated for veterans to receive robotic surgery at the facility, which staff began to offer. The OIG found facility leaders addressed veterans' concerns and made no recommendations.

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[33] 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.

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

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

[33] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[34] 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.[35]

Figure 8. *Facility photo.*
Source: "Northport VA Medical Center," Department of Veterans Affairs, accessed May 13, 2024, https://www.va.gov/northport-health-care/locations/.

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.

The OIG used a navigation link from the facility's website to follow directions to the facility but was unable to locate it. Instead, the OIG followed street signs directing drivers to the facility, which was successful.

The OIG observed that the facility's entrance had signs leading to a security checkpoint. The OIG used posted signage to navigate to the valet parking and various other parking areas, which

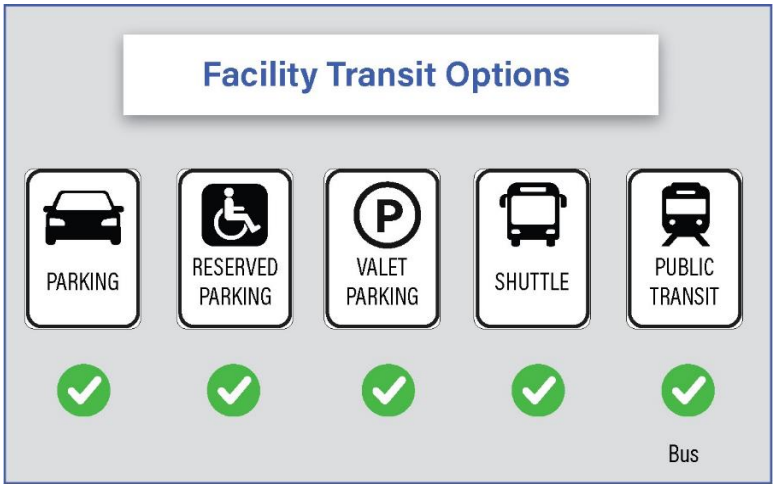


Figure 9. *Transit options for arriving at the facility.*
Source: OIG observations, analysis of documents, and interview.

[34] 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.

[35] 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.

had emergency lights and a phone. The OIG also observed construction that limited parking spaces and prevented visitors from driving and dropping off veterans at the main entrance. The Director informed the OIG about a construction project to replace the roadways and parking lots around the main entrance and Emergency Department. During an interview, the OIG learned that leaders had increased signage with directions to parking locations and valet services. The OIG found the facility ensured sufficient transit and parking options and made no recommendations.

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

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[36]

The main lobby had an information desk, café, seating area, artwork, and large windows that allowed for natural light. Near the information desk, the OIG noted several kiosks for patients to check in and get directions to their appointments. The OIG also saw an active water leak from the roof in the main lobby, and staff immediately addressed the issue by placing a container to capture dripping water to minimize fall risks. The Chief of Engineering reported being aware of the situation, attributing the leak to the current roof construction project.

Figure 11. *Facility information desk and kiosk in the main lobby.*
Source: Photo taken by OIG inspector.

Despite the active water leak in the main lobby, the OIG's overall impression was the entrance had a welcoming atmosphere. The OIG made no recommendations.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined

[36] 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*.

whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[37]

The OIG observed clear signage and readily available staff and volunteers to guide veterans through the facility. In the main lobby, the OIG observed patient support representatives assisting veterans using kiosks to print appointment information and turn-by-turn directions to their appointment locations. A representative stated they had received training to assist veterans in navigating the facility.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[38] In the main lobby, the OIG observed accessibility features, including braille on elevator doors and acoustic tiles that reduced noise levels.

The OIG noted a map located in front of the information desk in the main lobby; however, the map was difficult to read due to a protective screen. The OIG suggests staff explore alternative options for the map's covering. Another map, located near the main lobby, indicated different areas of the facility through color coordination.

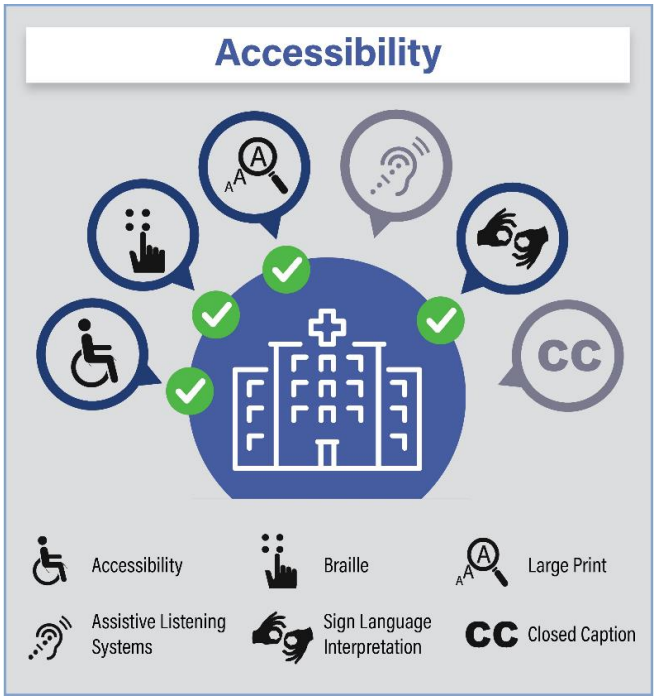


Figure 12. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

The OIG observed a veteran attempting to use a kiosk in the main lobby. The kiosk had an audio function that required headphones so veterans could hear check-in directions, but there were no headphones available or signs to indicate headphones were required. When asked by the OIG to check the kiosk's accessibility feature, the patient support representative and a facility leader said they did not know how to use it.[39]

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

[38] 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.

[39] VHA Directive 1850.05.

Despite multiple accessibility options for sensory-impaired veterans, the OIG identified potential difficulties for veterans with sensory impairments when using the kiosk. The OIG recommends facility leaders confirm staff are knowledgeable about how the lobby kiosks function to assist veterans with sensory impairments.

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.[40]

During an interview, the Chief of Primary Care and toxic exposure screening staff told the OIG that there were two toxic exposure screening navigators, and most patients received screenings in conjunction with a primary care appointment. The OIG did not find toxic exposure screening resources or signs in the main lobby or primary care clinics; however, staff placed toxic exposure pamphlets and posters in those areas during the week of the site visit. The OIG made no recommendations.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[41]

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

The OIG noted a recurring issue with leaking roofs. In interviews with facility leaders, the OIG learned leaders were aware and had multiple construction projects in progress to address the issue. The OIG made no recommendations.

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,

[40] 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.

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

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

In a review of documents, the OIG found that executive leaders did not consistently attend environment of care inspections during FY 2023. The Associate Director and the Chair of the Comprehensive Environment of Care Committee said leaders had identified the issue of their inconsistent participation during inspections and implemented an action plan, which resulted in sustained compliance for the last quarter of FY 2023 and the first quarter of FY 2024. Because leaders had demonstrated sustained compliance, the OIG made no recommendation.

The OIG inspected a primary care outpatient clinic, medical/surgical and critical care inpatient units, the Emergency Department, and four community living centers. The OIG found a clean and well-maintained healthcare environment, readily available personal protective equipment, and unobstructed exits in all locations reviewed. This was a marked improvement from the previous OIG inspection in 2018 in which inspectors identified a widespread lack of cleanliness in patient care areas and the presence of insects and insect residue in the community living centers and Emergency Department.[42]

During the Emergency Department inspection, the OIG found an unsecured area that contained medications and the supplies used to administer medications. The OIG also observed an unattended injectable medication and syringe and multiple open cabinets containing medications and supplies. Unsecured medications and supplies pose a safety risk because the items could be tampered with or stolen. The Nurse Manager informed the OIG that the department's current location was temporary pending construction of the new Emergency Department. The manager took immediate action to secure the medications and supplies. The OIG recommends facility leaders ensure staff secure all medications and the supplies used to administer them in the Emergency Department.

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.

[42] VA OIG, *Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center, New York*, Report No. 18-01018-281, September 18, 2018.

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.

Through a review of the facility's standard operating procedures and interviews with leaders, the OIG determined leaders had established processes to manage the communication of urgent, noncritical test results between diagnostic providers and ordering providers. The Chief of Staff and Chief of Primary Care described a process that ensured staff addressed urgent, noncritical test results when the ordering provider was unavailable, had left the facility, or when results became available outside of clinic hours. Facility leaders emphasized they had identified no significant issues with the communication of these test results.

The Chief of Primary Care and the Chief Health Informatics Officer acknowledged that an excessive number of electronic test result notifications could lead to alert fatigue—when providers become desensitized to alerts and may miss or fail to respond to test results. During an interview, the Deputy Chief of Staff and a staff member reported that alert fatigue was hindering workflow efficiency; providers had insufficient time allocated to address electronic notifications, so they had to work beyond their scheduled hours to complete the work. The Deputy Chief of Staff also stated that leaders had addressed these concerns by directing the informatics team to eliminate unnecessary notifications. The Primary Care Nurse Manager added that nurses also reported an excessive number of electronic notifications and collaborated with the informatics team to resolve the issue. The OIG determined facility leaders had a process to communicate urgent, noncritical test results to ordering providers and made no recommendation.

[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.

Action Plan Implementation and Sustainability

Figure 13. *Status of prior OIG recommendations.*
Source: OIG analysis of documents.

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[45] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG reviewed previously published OIG reports and found no open recommendations.[46] The Acting Chief of Quality Management confirmed the facility had no current or previous action plans related to the communication of test results. The OIG did not identify barriers to action plan improvements and made no recommendation.

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.[47] 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.[48] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Facility leaders shared processes to identify opportunities for improvement related to patient safety that included staff performing clinical reviews of patient care, monitoring adverse event data for trends, and conducting root cause analyses for systemic issues.[49] The Systems Redesign Coordinator said the facility had 71 process improvement projects at different stages, which were shared at Quality Improvement Infusion Council quarterly meetings. The OIG determined facility leaders and staff engaged in continuous learning through process improvement and made no recommendation.

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

[46] VA OIG, *Comprehensive Healthcare Inspection of the Northport VA Medical Center in New York*, Report No. 21-00300-130, May 5, 2022.

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

[48] VHA Directive 1050.01(1).

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

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[50] 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.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Prior to the OIG's site visit, the facility liaison identified 13 primary care team vacancies in the past 12 months. However, during the week of the inspection, the Primary Care Nurse Manager and the Chief of Primary Care reported only 4 current clinical vacancies, with candidates selected for each position. Also, the Chief of Business Office stated there were 3 advanced medical support assistant vacancies.

During interviews, the Primary Care Nurse Manager said there were no issues with nurse recruitment and leaders filled vacancies quickly. Additionally, the Deputy Chief of Staff emphasized the effectiveness of primary care teams deploying licensed practical nurses and medical support assistants across multiple teams to balance the workload when there were vacancies.

When asked about challenges filling primary care physician positions promptly, the Chief of Primary Care cited difficulties competing with the private sector physicians' higher pay. The Chief of Primary Care highlighted elements that make the VA more attractive than the private sector, including work-life balance and recruitment incentives such as education debt reduction.

[50] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, February 29, 2024.

[51] 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).

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

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[53] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[54]

In interviews, the Patient Centered Management Module Coordinator and Chief of Primary Care said they met daily with the Primary Care Nurse Manager, health system specialist, business office clinic managers, and a primary care physician to review panel data and adjust staffing to maintain manageable panel sizes. The Chief of Primary Care reported that the Operation Enduring Freedom-Operation Iraqi Freedom primary care team surpassed 100 percent panel capacity. Facility leaders responded by establishing a second team to meet the demand. The OIG also learned leaders had established a new women's primary care team in the past 12 months to offset the increasing panel size in the existing women's primary care team.

When the OIG asked primary care team members whether workloads were reasonable given the staffing levels, members affirmed that staffing levels allowed the teams to adequately care for patients. A primary care physician emphasized that despite treating many elderly patients with multiple and complicated medical conditions, the workload and panel size were reasonable.

The OIG found that primary care leaders were actively addressing staffing vacancies, and facility and primary care leaders kept abreast of staffing issues through meetings and adjusted resources to ensure reasonable panel sizes. The OIG made no recommendation.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[55] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

During interviews, primary care leaders and team members informed the OIG that the time allotted to complete various tasks for patients, such as identify and coordinate patients' medical needs and administer necessary vaccinations, had negatively affected efficiency and workflow. To address these inefficiencies, the Primary Care Nurse Manager said staff asked patients to arrive a half hour earlier than their scheduled appointment time to complete these required tasks. The Chief of Primary Care confirmed that this process ensured patients met with the provider on time.

[53] "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).

[54] VHA Directive 1406(1).

[55] VHA Handbook 1101.10(2).

According to the Chief of Primary Care, these initiatives had reduced provider burnout. A primary care physician attested that, after these efforts, primary care staff were happier, experienced reduced stress, and had more time to address patients' needs effectively.

The OIG found leaders supported the primary care team members and noted examples of changes that had occurred because of concerns raised to leaders. The OIG made no recommendation.

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 a decline in veteran enrollments over the three years preceding the inspection. The Chief of Primary Care attributed the decline to patient deaths, relocations, or retirements to other parts of the country. The Director reported working with VSOs to identify community activities that facility staff could attend to conduct outreach and enroll veterans with the facility.

Facility leaders also discussed disseminating PACT Act information to staff and the community. They held a week-long PACT Act fair in coordination with Veterans Benefits Administration staff that offered education and toxic exposure screenings and provided VSOs with office space to address veterans' questions and concerns related to the PACT Act.

All primary care team members interviewed confirmed there had been no changes in wait times or appointment availability since the PACT Act's implementation. The OIG found that the act's implementation had not disrupted primary care workflows. The OIG made no recommendation.

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.[56]

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).[57] 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."[58]

The OIG found the facility met the HCHV5 target during FYs 2022 and 2023. However, a program staff member said they did not think the measure accurately reflected the housing needs of veterans in the area. For example, during program intake assessments, if veterans say they spent the night in the hospital, they would not be counted as unsheltered.

HCHV staff collaborated with Emergency Department staff for same-day admissions to the Contract Emergency Residential Services program. Staff explained that from a veteran's arrival at the Emergency Department to being housed through the program was a very quick transition from homelessness to shelter and support.

Figure 14. *A best practice for veteran engagement.*
Source: OIG interview.

The Chief of Social Work explained to the OIG that an HCHV staff member performed street outreach, but it did not yield many enrollees. Instead, HCHV staff identified and enrolled veterans by participating in the point-in-time count, meeting with community partners to review by-name lists, and targeting outreach to institutions such as hospitals, law enforcement agencies, and churches.[59] A program staff member reported that stand-down events were also successful in identifying veterans because those who attended were usually interested in homeless services.[60]

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

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

[58] 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.

[59] A by-name-list is "a single prioritized list that is created through the CoCs [Continuum of Care] coordinated entry process." "Using the By-Name List for Housing Prioritization," May 23, 2023, accessed September 27, 2024, https://homelessdata.com/knowledge-base. The Continuum of Care Program "is designed to promote a community-wide commitment to the goal of ending homelessness." "Continuum of Care Program," Department of Housing and Urban Development, accessed September 25, 2024, https://www.hud.gov/program_offices/comm_planning/coc.

[60] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to housing and treatment services, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

Additionally, HCHV staff told the OIG they received referrals from facility staff, local hospitals, libraries, and concerned neighbors. The Chief of Social Work also said the local area met criteria for "functional zero," indicating a low number of homeless veterans.[61]

The OIG found that HCHV staff effectively identified and enrolled veterans into the program and were knowledgeable about the program's performance measures. The OIG made no recommendation.

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]

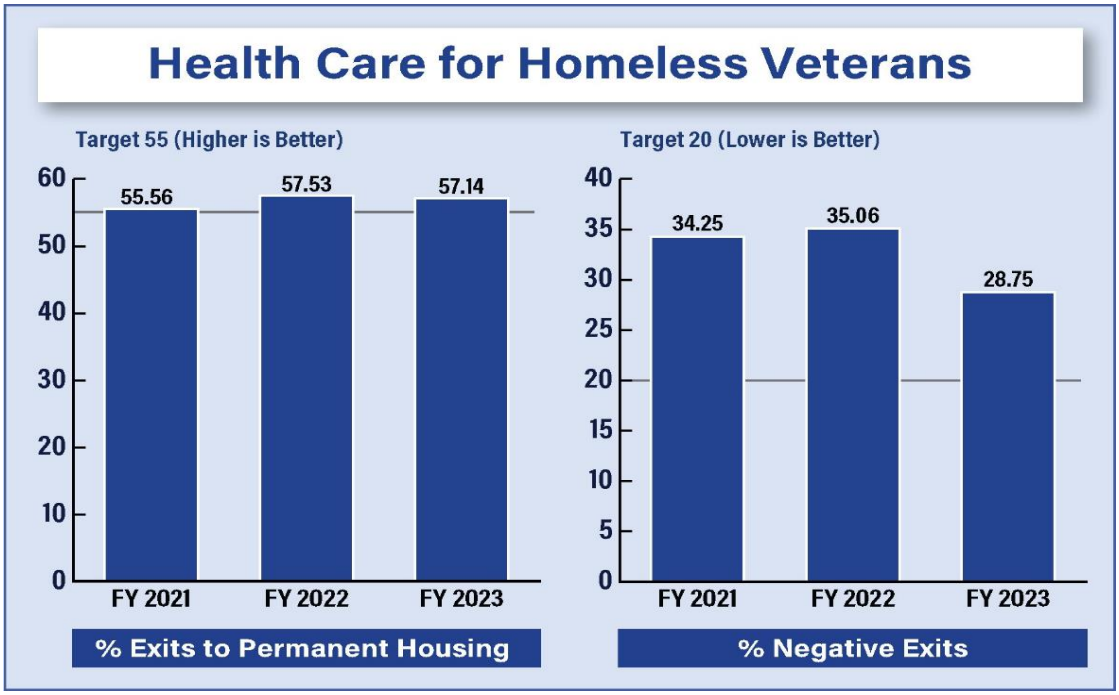

Figure 15. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The facility exceeded the HCHV1 target for FYs 2021 through 2023, and a program staff member told the OIG they believed the HCHV1 measure accurately reflected the number of

[61] "Functional zero is a dynamic milestone that indicates a community is continuously rendering homelessness rare overall and brief when it occurs, for a population." "Talking About Functional Zero," Built For Zero Community Solutions, accessed September 25, 2024, https://login.builtforzero.org/talking-about-functional-zero/.

[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 target (negative exits) was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

veterans achieving permanent housing. The Chief of Social Work attributed reaching the target in part to collaboration with other VA homeless programs. For example, some veterans transitioned directly from HCHV's Contract Emergency Residential Services to permanent housing using Housing and Urban Development–Veterans Affairs Supportive Housing vouchers.[63]

The facility did not meet the HCHV2 target from FY 2021 through FY 2023, and program staff said they did not view the measure as accurately reflecting veterans who were negatively discharged. For instance, veterans who reconnected with family and subsequently moved into their homes constituted negative exits in the database, despite veterans achieving housing goals. Staff added that the data did not capture veterans who reenrolled in the program after a negative exit. A program staff member collaborated with Contract Emergency Residential Services staff to increase engagement with veterans early in their admission, including on weekends, to decrease the likelihood of premature departure before achieving permanent housing.

Through an interview, the OIG learned that HCHV staff completed an assessment for each veteran admitted to the program to identify their needs. Further, each veteran in the Contract Emergency Residential Services program received a case manager. HCHV staff identified veterans' needs as finding permanent housing, securing employment, addressing mental health and substance abuse issues, and accessing VA benefits. A program staff member described holding weekly interdisciplinary team meetings with mental health, substance abuse, and Contract Emergency Residential Services staff to ensure continued services for veterans in need.

The Chief of Social Work highlighted the advantage of the Contract Emergency Residential Services program at the facility, which provided veterans easier access to mental health and substance abuse treatment as well as VA benefits coordination. A program staff member reported recognizing the program's impact through positive feedback from community partners and enrolled veterans.

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

Veterans Justice Program

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

[63] Contract emergency residential services programs provide safe living environments for veterans as they transition to other programs or to permanent housing. VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022.

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

VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[65]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each fiscal year (performance measure VJP1).[66] The facility exceeded the performance measure target during FY 2023. Program staff attributed their success to establishing strong relationships with jail and court staff and attending court arraignments that led to referrals. Staff added that the measure does not capture their work to enroll veterans because it did not encompass all the tasks they perform, such as traveling to and collaborating with the courts and developing veterans' treatment plans and referring them to other programs.

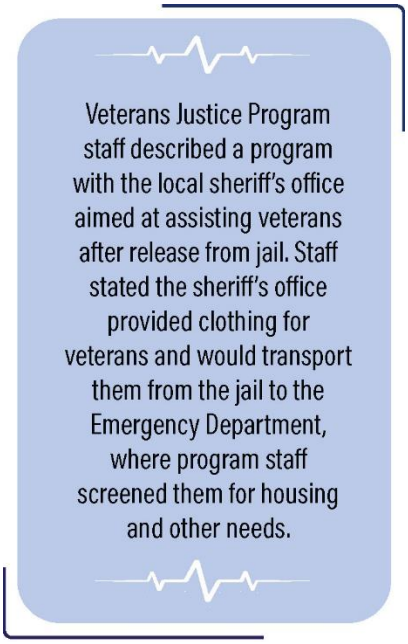

Figure 16. *Best practice related to the Veterans Justice Program. Source: OIG interview.*

During an interview with the OIG, program staff reported receiving referrals from facility staff and community partners. Staff said they did not perceive stigma as an issue for veterans in the program, emphasizing they treated veterans with respect during court proceedings. Staff shared a success story about a veteran enrolled in veterans treatment court who, with the support of program staff, participated in recommended treatment and an educational program, which led to the court reducing the felony charge to a noncriminal offense.[67]

Program staff reported conducting outreach within the facility by disseminating program information to social workers at their staff meetings, as well as in jails, district attorney offices, law enforcement facilities, law schools, and veterans treatment courts. Program staff reported no barriers to providing outreach.

The OIG found that staff provided effective outreach to identify and enroll veterans in the program and were knowledgeable about the program's performance measure. The OIG made no recommendation.

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

[66] 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*.

[67] Veterans treatment courts are "community initiatives that work to help Veterans get treatment for their unique clinical needs, within the context of the criminal justice system." "Justice Involved Veterans and Treatment Court," Office of Health Equity, Veterans Health Administration, Department of Veterans Affairs, accessed August 1, 2023, https://www.va.gov/HEALTHEQUITY/Justice_Involved_Veterans.pdf.

Meeting Veteran Needs

Program staff stated they knew about resources within the VA and the community and assessed veterans during program enrollment to determine their treatment needs. The OIG noted there were three veterans treatment courts within the program's service area. A program staff member reported meeting with court staff to discuss individual cases, share information and resources, and implement treatment plans tailored to each veteran's needs. Program staff discussed a mentor program coordinated by a local VSO to help veterans navigate court processes.[68]

The staff described challenges in meeting veterans' mental health and substance abuse treatment needs due to limited public transportation or veterans working during available treatment times. The Chief of Social Work explained that some veterans made multiple bus transfers to attend appointments, with trips lasting up to three hours. The chief added that VHA-Uber Health Connect was available to assist veterans with transportation but only for those who qualified for VA beneficiary travel.[69] The OIG made no recommendation but encourages facility leaders to explore options for offering evening appointments and alternative transportation for veterans seeking mental health and substance abuse treatment.

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."[70] 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.[71]

[68] The Nassau County Veterans Courts Mentor Program is a peer-to-peer program of volunteer veteran mentors who assist veterans in veterans treatment court by providing support and assistance in navigating court processes and accessing VA and other services. "Mentors," Nassau County New York, accessed May 8, 2024, https://www.nassaucountyny.gov/Mentors.

[69] VHA-Uber Health Connect "provides Veterans with a supplemental transportation option to get to and from approved medical appointments via Uber Health." "What is the VHA-Uber Health Connect (VUHC) Initiative?," accessed May 9, 2024, https://www.innovation.va.gov/ecosystem/VHA-Uber-Health-Connect-Initiative-FAQ.pdf. "The Beneficiary Travel (BT) program reimburses eligible Veterans for costs incurred while traveling to and from VA health care facilities." "Veterans Transportation Program (VTP)," Department of Veterans Affairs, accessed September 26, 2024, https://www.va.gov/HEALTHBENEFITS/vtp/index.asp.

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

[71] 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).[72]

The program did not meet the performance measure target in FYs 2021 or 2022 but exceeded it in FY 2023. A program staff member stated the primary barriers to meeting the target were limited available housing and the program's payment standard. A program staff member identified factors that contributed to meeting the target in FY 2023: assigning several program staff to focus on veterans' voucher use and increasing program enrollments from once a month to several times per month. Also, the Chief of Social Work informed the OIG the metric failed to fully capture their work to house veterans because it did not account for efforts to assist enrolled veterans who did not become permanently housed.

A program staff member identified several barriers to enrolling veterans, including limited available housing, program payment standards below typical housing costs, and a higher demand for vouchers than the facility's allotment. To address the challenges of finding affordable housing, a program staff member reported establishing an internal task force. The task force formed connections with a local board of realtors and collaborated with the program's housing specialist, who identified and engaged new landlords willing to accept housing vouchers. A program staff member stated that during 2022, the program's payment standard for a one-bedroom apartment increased from $1,800 to $2,200, which significantly improved access to permanent housing. Also, a program staff member planned to request additional vouchers in the upcoming reallocation request from the VA national program office.

A program staff member informed the OIG that the HCHV program, VA Grant and Per Diem Program, community shelters, and self-referral were the primary sources staff used to identify and enroll veterans in the program.[73] Then, staff contacted veterans within 24 hours of the referral to initiate services and coordinate care.

The OIG found program staff effectively identified and enrolled veterans into the program and were knowledgeable of the program's performance measure. The OIG made no recommendation.

[72] 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*.

[73] Grant and Per Diem is one of VA's homeless programs. It funds "community agencies providing services to Veterans experiencing homelessness." "VA Homeless Programs, Grant and Per Diem Program," Department of Veterans Affairs, accessed April 25, 2024, https://www.va.gov/homeless/gpd.asp.

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).[74]

The facility exceeded the performance measure target from FY 2021 through FY 2023. The Chief of Social Work attributed this achievement in part to the accessibility of the Community Employment Coordinator, who supported veterans seeking employment. However, the chief stated they do not view the performance measure as an accurate reflection of their work because employment is a personal choice. Additionally, the measure does not account for resources staff spend on case management of housed veterans.

Figure 17. *Homeless veterans. Source: OIG interview.*

Housing and Urban Development–Veterans Affairs Supportive Housing program staff reported collaborating with community partners to meet veterans' needs. One community partner trained veterans on financial literacy and credit repair at the facility, and another supplied them with mattresses and essential kitchen items. Program staff shared that community partners also assisted some veterans with security deposits and move-in fees, while a local foundation offered car repairs.

To identify veterans' needs, a program staff member described completing evaluations and treatment planning. Staff asked veterans what they identified as their greatest need, and case managers met with veterans regularly to address ongoing needs and mental health concerns.

One challenge a program staff member shared with the OIG was VHA's requirement for face-to-face visits. Per VHA policy, program staff must conduct home visits with veterans weekly, twice a month, or monthly, based on the veteran's needs.[75] A program staff member shared that flexibility to use telehealth or phone, in addition to face-to-face visits, could help resolve this challenge.

The OIG found program staff understood the program's performance measure and effectively collaborated with other VA services and community partners to meet the needs of enrolled veterans. The OIG made no recommendation.

[74] 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*.

[75] VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program*, June 29, 2017, amended June 24, 2024.

Conclusion

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

Summary of Findings and Recommendations

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

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

Major

Finding: In the Emergency Department, the OIG observed an unsecured area containing medications and the supplies used to administer them, with multiple open cabinets and an unattended injectable medication and syringe.

Recommendation 1: The OIG recommends facility leaders ensure staff secure all medications and the supplies used to administer medications in the Emergency Department.

Minor

Finding: The OIG observed accessibility options for sensory-impaired veterans but determined staff's lack of knowledge posed difficulties for veterans using the lobby kiosks.

Recommendation 2: The OIG recommends facility leaders confirm staff are knowledgeable about how the lobby kiosks function to assist veterans with sensory impairments.

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 April 16 through April 18, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 7, 2024

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

Subj: Healthcare Facility Inspection of the VA Northport Healthcare System in New York

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

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

I have reviewed the responses to the OIG HFI recommendations from Northport VA Medical Center. I concur with the findings, recommendations and the submitted action plans to resolve them.

(Original signed by:)

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

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 4, 2024

From: Director, VA Northport Healthcare System (632)

Subj: Healthcare Facility Inspection of the VA Northport Healthcare System in New York

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

As the Medical Center Director, I have reviewed the responses to the OIG HFI recommendations. I concur with the written responses.

(Original signed by:)

Antonio Sanchez, MD MHSA, FAPA, FACHE
Executive Director (Medical Center Director)
Northport VA Medical Center (632)

Appendix E: VA Responses

Recommendation 1

The OIG recommends facility leaders ensure staff secure all medications and the supplies used to administer medications in the Emergency Department.

__X__Concur

_____Nonconcur

Target date for completion: May 1, 2025

Director Comments

The VA Northport Emergency Department (ED) is currently under construction and a room was utilized to store medications and not secured properly. ED staff were re-educated on Medication Security/Safety by the ED Nurse Manager. A lock was placed on the storage room door by Engineering. Medications stored in the unlocked cabinets in the main ED have been transferred to the Omnicell to ensure that they are secured. A small number of medications will be transferred to a secure portable cart to ensure that medications are available for staff during emergencies in the ED. ED staff will ensure that the medication storage room and storage cart are secured daily and implemented a log to ensure that checks are completed.

- Nursing Leadership will audit monthly daily logs to ensure 90% compliance rate for 6 months.
- Nursing Leadership will perform weekly spot checks to ensure that the room and the cart with medication storage are secured to ensure 90% compliance rate for 6 months.
- Compliance will be reported monthly to the Nursing Leadership meeting by the ADPCS and then to the Quality and Patient Safety Committee meeting.

Recommendation 2

The OIG recommends facility leaders confirm staff are knowledgeable about how the lobby kiosks function to assist veterans with sensory impairments.

__X__Concur

_____Nonconcur

Target date for completion: December 1, 2024

Director Comments

The VA Northport Business Office will meet with the Vendor to review the capabilities for the information kiosks. The Business Office has requested additional disposable headphones from Logistics. Education and supply of disposable headphones will be provided to Patient Service Representatives and staff at all locations with information kiosks. Signage for the use of the disposable headphones will be posted next to the kiosks.

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