US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio

| Healthcare Facility Inspection | 24-00550-32 | January 8, 2025 |
|---|---|---|

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

## OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

## CONNECT WITH US

**Subscribe** to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

## PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

# 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 Chillicothe Healthcare System from May 21 through May 22, 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 leaders had addressed multiple system shocks that included turnover in leadership positions, a market assessment that resulted in a recommendation to close the facility, and a patient suicide on site.[2] Based on responses to the OIG's questionnaire, most employees perceived leaders had effectively addressed the shocks.

Leaders described communicating with staff in multiple ways, such as through town halls, visits to staff in work areas, and newsletters. The OIG found their efforts to be effective in fostering direct and open communication. Leaders described a focus on employee well-being, which

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

[2] The Asset and Infrastructure Review Commission was a VA initiative to study the current and future healthcare needs of the veteran population, as well as healthcare facility infrastructure. This report included a recommendation to close the facility and relocate services to other facilities or refer patients to community providers. "VA Recommendations to the AIR [Asset and Infrastructure Review] Commission," Department of Veterans Affairs, updated March 14, 2022, accessed April 26, 2024, https://www.va.gov/AIRCOMMISSIONREPORT/index.asp; Department of Veterans Affairs, *VA Recommendations to the Asset and Infrastructure Review Commission VISN 10 Market Recommendations*, March 2022, https://www.va.gov/VISN10-Market-Recommendation.pdf.

included multiple efforts to increase employee morale and motivation. Leaders also maintained collaborative relationships with local veteran service organizations to learn about veterans' complaints and respond to their needs.

## Environment of Care

The OIG examined the entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG physically inspected patient care areas, focusing on safety, cleanliness, infection prevention, and privacy. The OIG also compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

The OIG assessed signage as clear and visible, and accommodations for navigation were generally available to assist veterans with sensory impairments. The OIG reviewed the accessibility of the toxic exposure screening navigators, including wait times for screenings, and found no barriers. The OIG also reviewed the performance of the facility's Environment of Care Committee. The committee had identified a recurring issue with staff separating clean and dirty items in storage areas. During the OIG's physical inspection, staff were unable to articulate procedures for cleaning some reusable medical equipment or confirm whether they stored clean and dirty items separately. The OIG made one recommendation. The OIG also observed stained ceiling tiles in all inspected areas, which staff said was a recurring issue due to the heating and cooling system. The OIG did not issue a recommendation because leaders planned to improve the system.

## 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 managed communication of urgent test results between diagnostic and ordering providers, and ordering providers and patients, through established processes. The facility did not have open recommendations from previous reports. During interviews, the OIG learned that leaders employed various review processes to identify opportunities for improvement. Staff described a recent improvement project focused on outgoing providers communicating ordered laboratory and imaging tests to oncoming providers during shift changes.

## Primary Care

The OIG examined 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.[3] Primary care leaders created multiple new teams in the previous year to maintain reasonable panel sizes (number of patients assigned to a care team) and ensure patients' timely access to care.

Although leaders implemented projects to improve work efficiency, primary care staff told the OIG that leaders did not incorporate their feedback into process improvement projects. The OIG made one recommendation.

### 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 homeless program staff effectively enrolled veterans in homeless programs and coordinated care through referrals to community partners, community residential programs, and to the facility for various healthcare services.

Homeless program staff exceeded targets for the number of veterans discharged from the program into permanent housing. Staff attributed it to strong relationships with landlords and community organizations. However, staff mentioned the difficulty finding landlords willing to rent to veterans who had a criminal history or past eviction. Staff highlighted Freedom's Path, an apartment complex on the facility site where veterans can rent units using housing vouchers.

## What the OIG Recommended

The OIG made two recommendations.

1. The OIG recommends facility leaders ensure staff understand procedures for cleaning equipment and continue to monitor the physical separation of clean and dirty items in storage spaces.
2. The OIG recommends primary care leaders incorporate feedback from primary care staff and include them in process improvement projects.

## VA Comments and OIG Response

The Veterans Integrated Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable action plans (see appendixes D, E, and F

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

for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

# Abbreviations

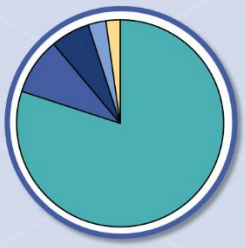
| | |
|---|---|
| ADPCS/NE | Associate Director for Patient Care Services/Nurse Executive |
| FY | fiscal year |
| HCHV | Health Care for Homeless Veterans |
| HRO | high reliability organization |
| OIG | Office of Inspector General |
| PACT | Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics |
| VHA | Veterans Health Administration |
| VSO | veterans service organization |

# FACILITY IN CONTEXT

**VA Chillicothe Healthcare System**
**Chillicothe, Ohio**
Level 3-Low Complexity
Ross County
Hospital Referral Region: Columbus

## Description of Community

### RACE AND ETHNICITY




### MEDIAN INCOME

**$53,644**

### EDUCATION

**89%** Completed High School
**54%** Some College

### VIOLENT CRIME

Reported Offenses per 100,000 **114**

### POPULATION

Female **2,558,701**
Male **2,505,859**
Veteran Female **30,350**
Veteran Male **279,398**

Homeless - State **10,654**
Homeless Veteran -State **633**

### UNEMPLOYMENT RATE

**5%** Unemployed Rate 16+
**4%** Veterans Unemployed in Civilian Workforce

### SUBSTANCE USE

**28.7%** Driving Deaths Involving Alcohol
**18.4%** Excessive Drinking
**2,246** Drug Overdose Deaths

### TRANSPORTATION

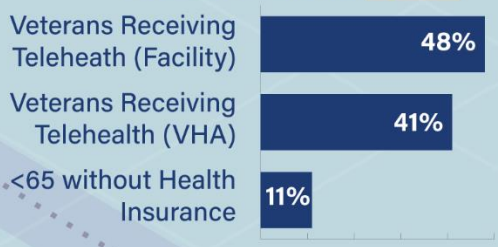

### AVERAGE DRIVE TO CLOSEST VA

| | |
|---|---|
| Primary Care | **25 Minutes, 20 Miles** |
| Specialty Care | **59 Minutes, 54.5 Miles** |
| Tertiary Care | **125 Minutes, 127.5 Miles** |

## Access to Health Care

### ACCESS

VA Medical Center Telehealth Patients 9,385



# Health of the Veteran Population

**VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY**

**6,712**

**202** VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

**AVERAGE INPATIENT HOSPITAL LENGTH OF STAY**

**N/A**

**30-DAY READMISSION RATE**

**N/A**

## SUICIDE RATE PER 100,000

| Suicide Rate (state level) | Veteran Suicide Rate (state level) |
|---|---|
| 19 | 34 |

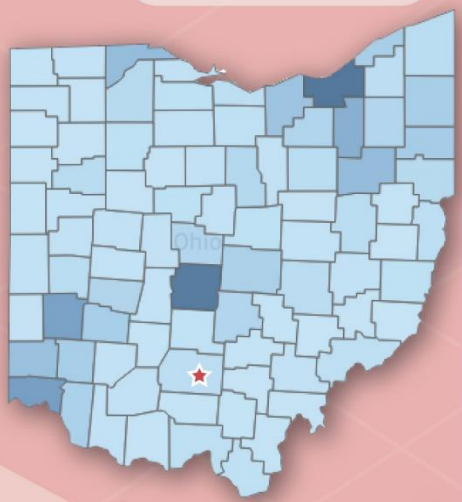
# Health of the Facility

## UNIQUE PATIENTS

| | |
|---|---|
| Unique Patients VA and Non-VA Care | 23K |
| Unique Patients VA Care | 21K |
| Unique Patients Non-VA Care | 14K |

★ VA MEDICAL CENTER VETERAN POPULATION

809 — 67,325



## COMMUNITY CARE COSTS

| | |
|---|---|
| Unique Patient $15,326 | Outpatient Visit $279 |
| Line Item $574 | Bed Day of Care $251 |

## STAFF RETENTION

| | |
|---|---|
| Onboard Employees Stay <1 Yr | 14.68% |
| Facility Total Loss Rate | 11.64% |
| Facility Retire Rate | 2.27% |
| Facility Quit Rate | 8.36% |
| Facility Termination Rate | 0.94% |

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

# Contents

# Background and Vision

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

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


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

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

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

leaders and staff by noting specific actions they can take to improve patient safety and care.

## High Reliability Organization Framework

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

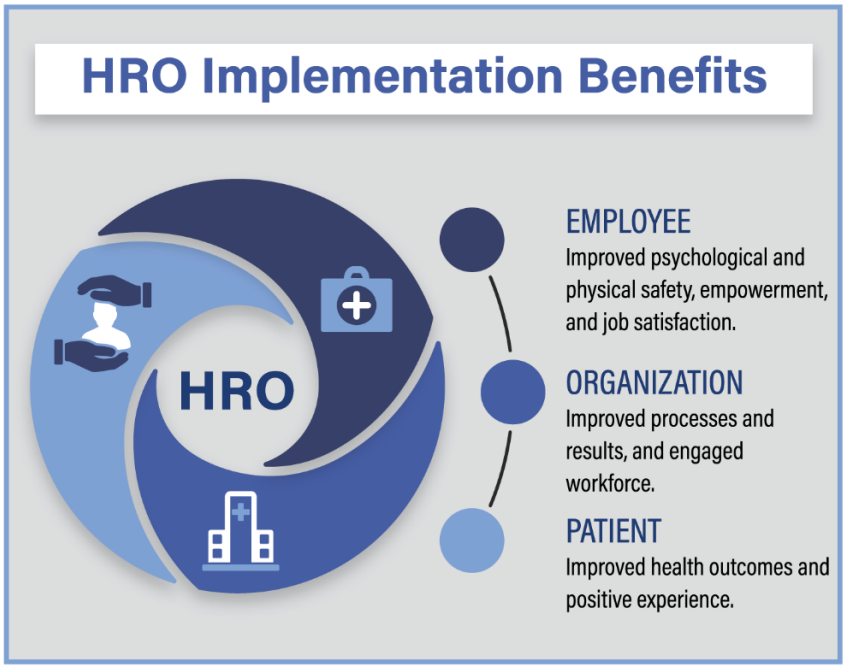



***Figure 2.*** *Potential benefits of HRO implementation.*
*Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

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

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

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

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

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

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

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

## PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

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

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

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

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

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

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

# 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 Chillicothe Healthcare System (facility) first opened on June 8, 1917, as a military training center and became a Veterans Bureau hospital in 1924. At the time of the inspection, the facility's executive leaders consisted of a Director, Chief of Staff, Associate Director for Patient Care Services/Nurse Executive (ADPCS/NE), Associate Director, and Assistant Director. In fiscal year (FY) 2023, the facility's medical care budget was approximately $406 million. The facility had 198 operating beds, which included 41 hospital beds, 122 community living center beds, and 35 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 VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

## System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational

[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/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp.

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

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

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

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.


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

During interviews, facility leaders described multiple events that caused significant system shocks to the organization. These events included leadership turnover, a market assessment that resulted in a recommendation to close the facility, and a patient suicide on site.[19]

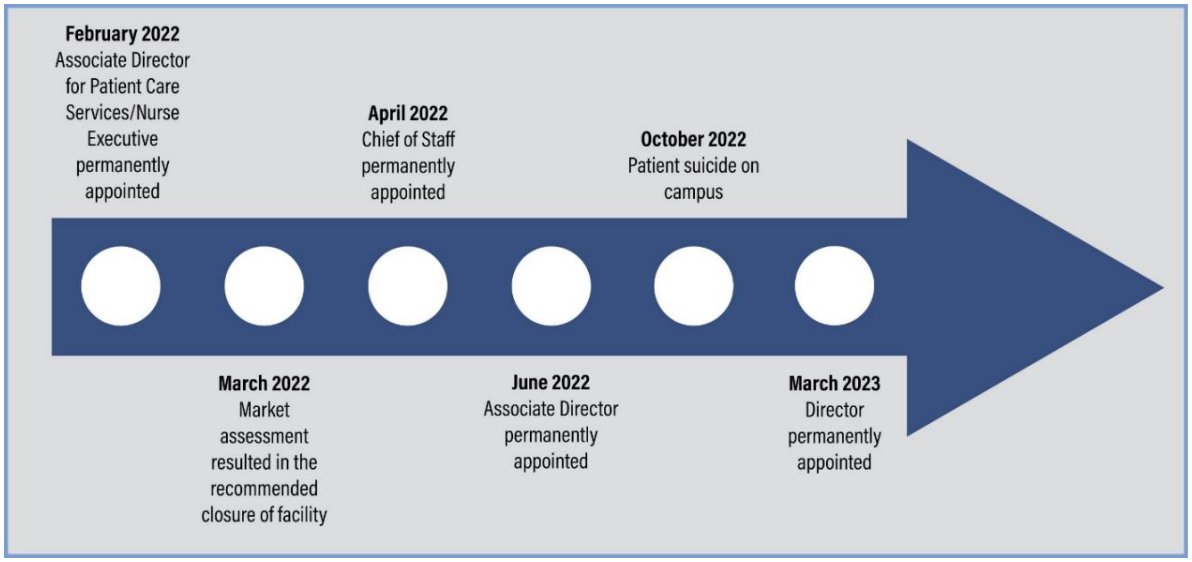



***Figure 5.*** *Timeline of facility system shocks.*
*Source: OIG interviews.*

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

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

[19] The Asset and Infrastructure Review Commission was a VA initiative to study the current and future healthcare needs of the veteran population, as well as healthcare facility infrastructure. This report included a recommendation to close the facility and relocate services to other facilities or refer patients to community providers. "VA Recommendations to the AIR [Asset and Infrastructure Review] Commission," Department of Veterans Affairs, updated March 14, 2022, accessed April 26, 2024, https://www.va.gov/AIRCOMMISSIONREPORT/index.asp; Department of Veterans Affairs, *VA Recommendations to the Asset and Infrastructure Review Commission VISN 10 Market Recommendations*, March 2022, https://www.va.gov/VISN10-Market-Recommendation.pdf.

Leaders explained to OIG that in 2022, three new leaders were appointed to their positions around the same time the market assessment resulted in the recommendation to close the facility. Leaders said the closure announcement led to an outpouring of support from senators, stakeholders, and veterans who wanted the facility to remain open. According to the leaders, the facility remained open because of the support.

In late 2022, a patient suicide occurred at the facility. The ADPCS/NE described being aware that staff needed to heal and being available to them as needed. The leader held a celebration of life to acknowledge the loss and instructed staff to call anytime, sometimes responding to messages and phone calls in the middle of the night.

Most respondents to the OIG's questionnaire perceived leaders' actions had effectively addressed the system shocks.[20] The OIG found leaders were effective in managing the challenges and made no recommendations.

## Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[22] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]


***Figure 6.*** *Leader communication with staff.*
*Source: Comments from the OIG questionnaire.*

[20] The VA Chillicothe Healthcare System had 1,650 employees, and 208 of them responded to the questionnaire.

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

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

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

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

All Employee Survey responses indicated employees' perceptions of leaders' transparency and communication had improved within the last two years. The OIG questionnaire showed most respondents felt communication was frequent, clear, and had improved over previous efforts.

Leaders discussed communicating with employees through a variety of means, including

- weekly all employee town halls,
- weekly supervisor town halls,
- community-based outpatient clinic town halls,
- nursing town halls,
- regular visits to staff in work areas, and
- newsletters.


***Figure 7.*** *Town halls.*
*Source: OIG interview.*

During interviews, the Director reported believing staff who receive clear communication could better connect to the mission of providing high-quality health care to veterans. Leaders stated that at the end of meetings, they agree on the message they would share with employees to ensure consistent communication.

Leaders identified employee availability to attend town halls as a barrier to communication; therefore, they recorded the town halls to be available to employees at their convenience. The OIG found leaders' efforts to facilitate direct and open communication were effective 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.[25] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[26] Organizations with cultures that celebrate diversity and inclusion


***Figure 8.*** *Facility workforce diversity.*
*Source: Facility human resources data.*

[25] 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.

[26] 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.

encourage self-expression and enhance psychological safety, part of the safety culture, which is foundational to an HRO.[27] 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.[28] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.

All Employee Survey responses indicated staff's perception of workplace diversity had increased over the last three years. The OIG also reviewed human resources data and noted that the number of employees with disabilities had increased, but the number of veteran employees had decreased. In interviews, leaders attributed the lower number of veteran employees to more non-veteran applicants and a miscount of veteran employees due to inaccurate documentation. For example, the ADPCS/NE recognized a list of veteran nurses on Veterans Day and later received multiple emails from nurses stating they were a veteran but not recognized. Therefore, leaders encouraged employees to verify their human resource information to ensure accurate documentation of veteran status.

The Director reported working with human resources staff to increase diversity in hiring, but their previous practice of sharing an off-site equal employment opportunity manager with another facility had been a barrier. Leaders said a newly hired on-site equal employment opportunity manager would improve hiring efforts to increase diversity. The OIG encourages leaders to continue efforts in hiring a diverse workforce but made no recommendations.

## Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[29] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[30] The OIG reviewed responses to the

[27] 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*.

[28] 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.pdf.

[29] 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.

[30] 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.

employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

All Employee Survey scores for best places to work increased from FY 2022 to FY 2023.[31] In interviews, leaders discussed unique factors that contributed to the employee experience. For example, the Director stated casual wear for employees had boosted morale, and veterans perceived casually dressed employees as more approachable. Additionally, each week started with a Monday motivation email that leaders sent to employees with positive feedback from veterans. Leaders also told the OIG about the facility's break rooms that contained massage chairs. The ADPCS/NE reported holding leadership meetings for nurse managers to provide them with the training and support they needed to support employees.

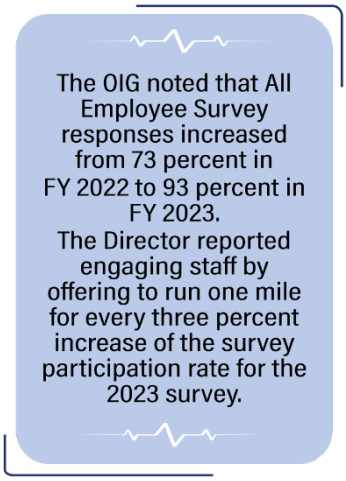



***Figure 9.*** *Survey participation. Source: OIG analysis of documents and interviews.*

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. All Employee Survey scores for psychological safety had also increased over the past three years, and the OIG-administered questionnaire showed most respondents felt comfortable reporting patient and employee concerns. As an example of improved psychological safety, the Chief of Quality and Patient Safety identified increased numbers of employees reporting patient events or concerns and asking leaders for feedback or resolutions.

Leaders informed the OIG during interviews about their Great Catch program, which they said enhanced patient and psychological safety at the facility. The Director said leaders developed the program to recognize employees with a pin when they stopped a potential safety event before anyone was harmed or inconvenienced (see appendix C, figure C.1). The OIG learned leaders awarded an employee a Great Catch pin for finding an error in documentation, working to have it corrected, and preventing a veteran from receiving numerous billing and nonpayment notifications.

The OIG found leaders were committed to improving the employee experience, and survey scores indicated employees generally felt psychologically safe to raise concerns. The OIG made no recommendations.

[31] Best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2020 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA Support Service Center.

## Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[32] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[33] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In a response to an OIG questionnaire, the Patient Advocate conveyed that facility leaders were responsive to veterans' concerns. The Patient Advocate stated that a lack of communication with providers and staff was the most frequent issue raised by veterans, and according to the advocate, the leaders had effectively addressed those concerns.

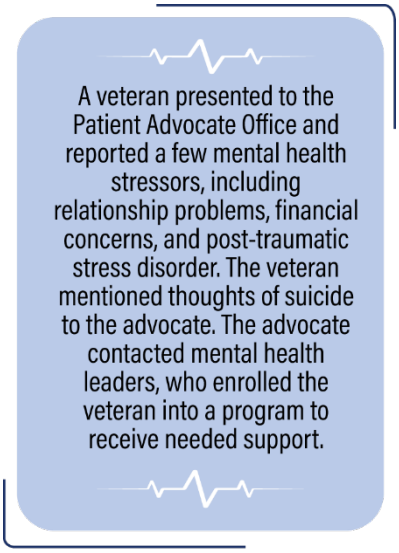



***Figure 10.*** *Patient Advocate intervention.*
*Source: OIG questionnaire.*

Most of the VSOs responding to the OIG's questionnaire strongly agreed that leaders were responsive to veterans' concerns. The VSO respondents reported hearing about a veteran's problems navigating the phone system and communicating directly with the veteran's care team. The Director shared a handout with the OIG designed to help veterans navigate the phone system and obtain the resources they frequently requested from facility staff. In interviews, leaders described having positive working relationships and continuous communication with the VSOs. The OIG found that leaders responded to veterans' concerns and made no recommendations.

# ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[34] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from

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

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

[34] VHA Directive 1608(1).

prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

## Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[35] 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.[36]

***Figure 11.*** *Facility photo.*
*Source: Photo taken by OIG inspector.*

## 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 the navigation link on the facility's website to successfully reach the administration building. The OIG located the Urgent Care and Welcome Center and observed ample parking with a bus stop near the entrance. The facility liaison

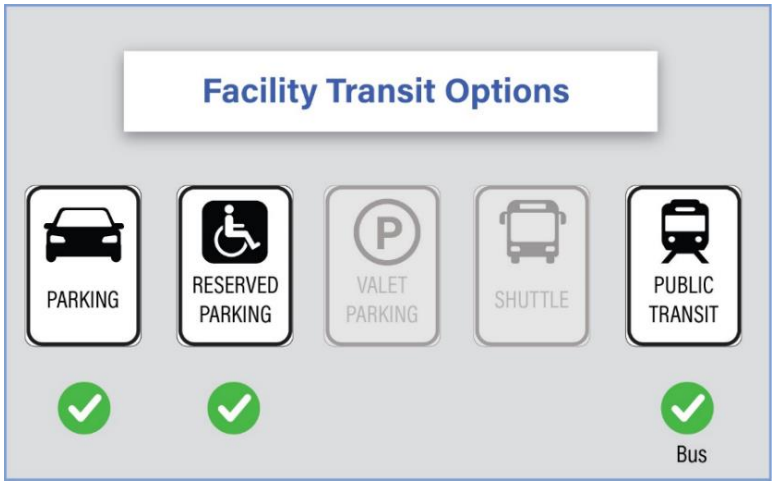



***Figure 12.*** *Transit options for arriving at the facility.*
*Source: OIG analysis of documents, interviews, and observations.*

[35] 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.

[36] 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.

told the OIG there were no valet parking or shuttle services available; however, the OIG learned during interviews that a shuttle was available to transport veterans between buildings.

## Main Entrance


***Figure 13.*** *Urgent Care and Welcome Center.*
*Source: Photo taken by OIG inspector.*

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[37]

The OIG identified the Welcome Center by signage on the building's overhang. The entrance was accessible by elevator, ramp, and stairs from the parking lot. The OIG entered the Welcome Center through power-assisted sliding doors and found the interior spacious and well-lit, with natural light from floor-to-ceiling windows (see appendix C, figure C.2). The OIG observed wheelchairs available near the door and an information desk with staff and volunteers to assist veterans. Although the OIG noted multiple seating options outside the Welcome Center, the interior lacked seating. The OIG made no recommendations.

## Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[38]

The OIG observed staff and volunteers at the information desk, who stated they provided directions or escorted veterans to their destinations. The OIG observed one printed map available in the Welcome Center, and staff added additional copies while the OIG was on site. The OIG noted maps and signs on the walls to help veterans navigate the facility, and the OIG easily found locations using these navigational cues. The Environment of Care Rounds Coordinator and the facility liaison reported that updates to signage and maps were an ongoing process, and staff made changes as needed to provide clear and easily navigable cues. The OIG assessed signage as clear and visible and was able to successfully navigate the facility.

[37] 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*.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[39]

The facility liaison said there was no specialized training provided to staff or volunteers to assist veterans with sensory impairments, but the Visual Impairment Services Team Coordinator was an available resource.[40] Welcome Center staff stated they would contact their supervisor for direction if they were unsure how to assist a sensory impaired veteran.


***Figure 14.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: Staff responses and OIG observations.*

During the physical inspection, the OIG noted audible signals at elevators and braille on signage around the facility. Although the OIG observed large print on the wall signs to help visually impaired veterans reach their destinations, it was not on the printed maps. However, in a review of patient advocate reports, the OIG found no concerns from veterans about accessibility features.

The OIG's overall impression was that accommodations were generally available to help veterans with sensory impairments navigate the facility. The OIG made no recommendations.

[39] 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/individuals-visual-impairments; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

[40] "VIST [Visual Impairment Services Team] Coordinators are case managers who have responsibility for coordinating care and services for severely disabled visually impaired Veterans." "Do You Know My VIST Coordinator?," Department of Veterans Affairs, accessed June 3, 2024, https://www.prosthetics.va.gov.asp.

## 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.[41]

The Chief, Primary Care and Pharmacy reported to the OIG that the facility had two navigators, although every provider could screen veterans for toxic exposure. The chief added that screenings were also available upon veterans' request. The OIG observed informational handouts regarding toxic exposure available for veterans, as well as signs posted at the facility. 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.[42] 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.

In a review of environment of care reports, the OIG noted the facility's Environment of Care Committee had identified the physical separation of clean and dirty items in storage areas as an opportunity for improvement and developed a process improvement plan for FY 2024. In an interview, the committee chair reported that lack of staff education was a large part of this recurring problem, so infection control staff educated other staff on appropriate storage during inspections.

During physical inspections, the OIG observed tags on equipment in storage rooms and patient care areas in a primary care clinic and the Urgent Care center. The tags were titled *Clean ready to use,* with dates written in (see appendix C, figure C.3). When asked the purpose for the tags, staff provided the OIG with inconsistent answers and could not say whether clean and dirty items were stored separately.

The OIG reviewed the facility's policy for cleaning noncritical, reusable medical equipment and noted staff were unable to articulate procedures for cleaning equipment in their areas of

[41] 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.

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

responsibility.[43] When staff are unaware if equipment is clean or dirty, there is an increased risk of infection if used. The OIG recommends that facility leaders ensure staff understand procedures for cleaning equipment and continue monitoring the physical separation of clean and dirty items in storage spaces.

## General Inspection

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

The OIG inspected three clinical areas and found them to be generally clean. The OIG observed clear exit paths and found no concerns with privacy in patient care areas. Although the OIG observed stained ceiling tiles in all the inspected areas, staff replaced them during the inspection. In an interview, the Chief, Facilities Management Service explained that stained ceiling tiles were a recurring issue due the facility's heating and cooling system; the insulation around pipes was old and deteriorating, causing leaks from water collecting on the pipes' surface. The chief added that one employee was responsible for replacing portions of the insulation until funding was available to improve the system. Because leaders were aware of the issue and addressing it, the OIG made no recommendation.


The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

## Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[44] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[43] Reusable medical devices "can be reprocessed and reused on multiple patients," with noncritical devices having the lowest degree of risk of infection associated with device use. VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

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

diagnostic and ordering provider teams and their patients.[45] 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 policy and interviews with leaders, the OIG determined the facility had established processes to manage the communication of urgent, noncritical test results between diagnostic and ordering providers, as well as between ordering providers and patients. The Chief of Diagnostics stated there were no challenges with the providers following the processes. The OIG made no recommendations.

## Action Plan Implementation and Sustainability


***Figure 15.*** *Status of prior OIG recommendations. Source: VA OIG.*

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

The OIG found, and the ADPCS/NE and Patient Safety Manager verified, that the facility had no current action plans that had been open longer than one year. The OIG did not identify barriers to action plans and made no recommendations related to their implementation and sustainability.

## 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.

[45] 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.

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

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

[48] VHA Directive 1050.01(1).

During interviews with the OIG, facility leaders described collaboration across departments as essential for identifying improvement opportunities and learning through process improvements. The Chief of Quality and Patient Safety, the Risk Manager, and the Patient Safety Manager reported identifying opportunities for improvement through various means, such as trends noted from the Peer Review Committee, reviews of patient safety events, and concerns raised by staff.

Facility staff reported a process improvement project that originated from a collaboration between the Peer Review Committee and the Patient Safety Manager. The project began shortly before the OIG inspection and focused on the communication during shift changes, ensuring that ordered laboratory and imaging tests were relayed from outgoing to oncoming providers. The OIG determined facility leaders and staff engage in continuous learning through process improvement and made no recommendations.


The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[49] 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.[50] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[51] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Prior to the inspection, the facility liaison reported 13 vacant primary care positions in the past 12 months, and the OIG noted physician positions had the most vacancies. During interviews, the Associate Chief of Primary Care and the Primary Care Section Chief reported physician recruitment was a challenge because of the facility's rural location.

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

[50] 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).

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

The primary care leaders shared that the Human Resource Recruiter assisted potential candidates through the hiring process. Primary care leaders reported multiple physicians had accepted primary care positions, leaving just one vacancy at the time of the inspection. The Primary Care Social Work Supervisor reported requesting additional social worker positions, which were pending approval from facility leaders.

When asked about nursing vacancies, the ADPCS/NE shared that the Nurse Recruiter conducted weekly hiring fairs and visited various schools to recruit candidates. In addition, the ADPCS/NE reported using community billboards and participating in radio interviews to promote open positions. The Primary Care Nurse Manager reported no barriers to recruiting nurses.

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.[52] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[53]

The Associate Chief of Primary Care told the OIG the primary care leaders, Patient Centered Management Module Coordinator, and Program Support Assistant met daily to review panel sizes. During interviews, the Chief Nurse for Primary Care and the Primary Care Nurse Manager stated leaders had created multiple new primary care teams in response to excessive panel sizes in the past year. At the time of the inspection, primary care leaders and staff agreed that panel sizes were generally reasonable.

The OIG found primary care leaders kept abreast of staffing issues through meetings and had created new teams to ensure reasonable panel sizes. The OIG made no recommendations.

## Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[54] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care leaders and staff informed the OIG that the consult process was the main issue affecting efficiency because there were too many steps involved to generate a consult, which was time consuming in addition to other clinical responsibilities. The Primary Care Section Chief and

[52] "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).

[53] VHA Directive 1406(1).

[54] VHA Handbook 1101.10(2).

the Associate Director of Primary Care told said they were aware of the issue and taking steps to improve the process.

In an interview, primary care staff stated that primary care leaders did not incorporate their feedback for improvements into projects; instead, they dictated decisions to the staff. When the OIG asked primary care leaders if frontline staff had given feedback or if leaders had an example of when they incorporated staff's ideas for efficiency into improvement projects, leaders were unable to provide any examples. Despite staff's concerns about not being involved in these projects, they stated that no patients were harmed, and they were able to care for the patients effectively. The OIG made one recommendation that primary care leaders incorporate the feedback from primary care staff and include them in process improvement projects.

## 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 veteran enrollment decreased in FYs 2021 and 2022 but increased in FY 2023. Despite the increase, primary care leaders and staff confirmed there had been no changes in wait times or appointment availability since the act's implementation. The OIG made no recommendations.


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

## Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[55]

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

## Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[56] 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."[57]

The facility did not meet the HCHV5 target in FYs 2021 or 2022. The facility was exempt from the metric in FY 2023 because the by-name list did not show any veterans experiencing street homelessness in the area, according to program staff.[58]

The HCHV staff told the OIG they did not believe the point-in-time count was an accurate reflection of unsheltered veterans. When staff participated in the count with a local organization, they found only belongings in encampments and believed the people had gone to shelters or found another place to stay because of the cold temperatures.

The HCHV staff identified alternative metrics to review program efforts. The Housing Program Supervisor reported the use of an annual survey for veterans as an indicator of program effectiveness, noting that veterans shared the impact the homeless program had made in their lives.

***Figure 16.*** *Measure of program effectiveness. Source: OIG interviews.*

The HCHV staff reported using internal and external referrals to identify veterans for program enrollment. The internal referrals came from the facility's substance abuse treatment program, residential rehabilitation treatment program, mental health programs, and Urgent Care center, as well as VA's national homeless hotline. External referrals came from homeless shelters, food pantries, community action agencies, and Supportive Services for Veteran Families.[59]

---

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

[57] 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.

[58] By-name lists are tools to help communities develop or improve their local list of homeless persons. "Veteran Master List Template and Benchmark Report Generation Tool," HUD Exchange, accessed October 7, 2024, https://www.hudexchange.info/resource/master-list-template-and-benchmark-generation-tool. Street homelessness occurs "in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[59] Community action agencies "work to alleviate poverty and empower low-income families in their communities" and serve all 88 counties in Ohio. "About Community Action," Ohio Association of Community Action Agencies, accessed June 3, 2024, https://oacaa.org/community-action/. Supportive Services for Veteran Families provides case management and support to prevent homelessness, "or to rapidly re-house veterans and their families." "Supportive Services for Veteran Families," Department of Veterans Affairs, accessed October 7, 2024, https://www.va.gov/homeless.

The Housing Program Supervisor reported community outreach efforts consisted of attending local Continuum of Care Program meetings and visiting VSO offices and local shelters.[60] The Housing Program Supervisor shared that there was little need for street outreach due to the rural service area. Staff said difficulty determining veterans' eligibility was infrequent, but they did not deny veterans care or shelter while obtaining eligibility information.

The OIG found staff were knowledgeable about the program's performance measure and effectively identified and enrolled veterans in the homeless program. The OIG made no recommendations.

## Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[61]

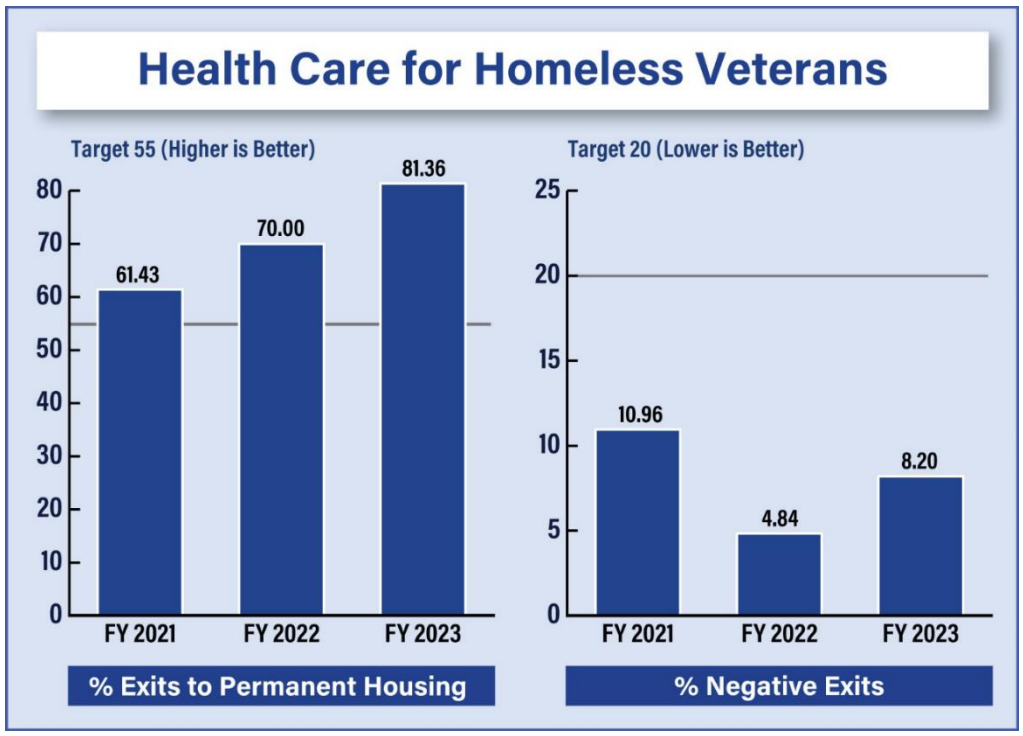



***Figure 17.*** *HCHV program performance measures.*
*Source: VHA Homeless Performance Measures data.*

[60] 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 October 7, 2024, https://www.hud.gov/program_offices/comm_planning/coc.

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

HCHV staff exceeded the HCHV1 target in FYs 2021, 2022, and 2023. The Housing Program Supervisor attributed this success to strong relationships with local landlords and community organizations. Additionally, the program had fewer negative exits than the HCHV2 target all three years. Program staff attributed this performance to factors such as weekly case conferencing with community partners, maintaining strong working relationships with other facility homeless staff, and establishing rapport with veterans in the program. The OIG concluded that these actions could lead to sooner intervention with veterans at risk of a negative exit and prevent it from occurring.

The OIG found HCHV staff effectively met the needs of enrolled veterans and were knowledgeable about the program's performance measures. The OIG made no recommendations.

## Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[62] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[63]

### Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[64] The facility met the performance measure target during FY 2023. The Housing Program Supervisor stated that program staff measured the effectiveness of community outreach and education by tracking the metric as well as the number of referrals the program received.

The Ohio State Patrol received calls regarding a person sitting in a car along the side of the road. The officer who responded determined the individual was a veteran and worked to transfer the veteran to a local emergency room for care. Emergency room staff discovered the veteran had used a controlled substance, and the officer alerted the VA program staff, who facilitated the veteran's admission to the facility's residential treatment program.

***Figure 18.*** *Veteran success story.*
*Source: OIG interview.*

The supervisor informed the OIG that program staff identified veterans involved in the legal system or who were recently incarcerated by using the Veterans Reentry Search Service, as well

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

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

[64] 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*.

as through self-referrals and community partner referrals.[65] Program staff reported educating the local sheriff, police officers, and staff at local jails about the program to increase referrals.

### Meeting Veteran Needs

The Housing Program Supervisor explained to the OIG that, after determining an appropriate level of care, program staff coordinated a veteran's care through referrals to community partners; community residential programs; and facility programs. Program staff referred veterans to facility primary and mental health care, housing and outpatient services, and substance use disorder and residential treatment.

The OIG concluded that program staff effectively identified and enrolled veterans into the program and were meeting their needs. The OIG made no recommendations.

## Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[66] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[67]

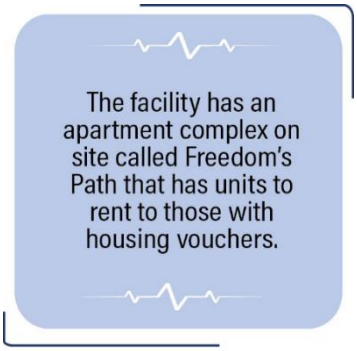



***Figure 519.*** *Best practice for veteran housing.*
*Source: OIG interview.*

### Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[68] The facility did not meet the performance measure target in FYs 2021, 2022, or 2023. The Housing Program Supervisor stated the program received additional vouchers that have been

[65] The Veterans Reentry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military." "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) – Terms and Conditions of Use," Department of Veterans Affairs, accessed June 4, 2024, https://vrss.va.gov. (This website is not publicly accessible.)

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

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

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

hard to use due to limited housing options and limited numbers of unsheltered veterans in the area. To address the challenge of having extra vouchers, staff conducted weekly phone calls with community partners to identify veterans who would be eligible for the program.

The staff also reported conducting community outreach at shelters, transitional housing, stand-down events, community action organizations, and VSO offices.[69] Once staff receive a referral, they assess the veteran to determine and address any immediate needs and develop a housing plan. However, staff cited difficulty finding landlords willing to participate in the program and accept veterans with a past eviction or criminal history. To overcome this barrier, they built ongoing relationships with landlords to increase available housing.

## 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).[70] The facility exceeded the performance measure target in FYs 2021 and 2022 but missed the FY 2023 target by less than 2 percent. Program staff shared that discrepancies in the Homeless Operations, Management and Evaluation System documentation contributed to staff not meeting the target in FY 2023. Program staff also told the OIG that some veterans might enter the program with a desire to work but have limited employment options due to health issues.[71] To address these issues, the community employment coordinator worked with the case managers, reviewed data to ensure the program's database accurately reflected veterans' employment status, and assisted veterans with resumes and transportation to interviews.

The OIG concluded that program staff were knowledgeable of the program's performance measures and effectively identified and enrolled veterans into the program and worked to meet their needs. The OIG made no recommendations.

[69] Stand Downs "are 1- to 3-day events that provide homeless Veterans a variety of services and allow VA and community-based service providers to reach more homeless Veterans. Stand Downs give homeless Veterans a temporary refuge where they can obtain food, housing assistance, clothing and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to long-term treatment, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1501, *VHA Homeless Programs,* October 21, 2016.

[70] 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*.

[71] "Homeless Operations, Management and Evaluation System (HOMES) is VA's primary platform for collecting intake, progress and outcome information for homeless Veterans." VHA Directive 1162.08.

# 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:** Staff were unaware of processes to clean equipment, distinguish clean from dirty equipment, or say whether clean and dirty items were stored separately.

**Recommendation 1:** The OIG recommends that facility leaders ensure staff understand procedures for cleaning equipment and continue to monitor the physical separation of clean and dirty items in storage spaces.

## Minor

**Finding:** Primary care staff stated primary care leaders did not include them in process improvement projects.

**Recommendation 2:** The OIG recommends that primary care leaders incorporate feedback from primary care staff and include them in process improvement projects.

# 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 May 21 through May 22, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

**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).*

## 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: Facility Pictures


***Figure C.1.*** *Chillicothe VA Medical Center's Great Catch pin.*
*Source: Photo taken by OIG inspector.*

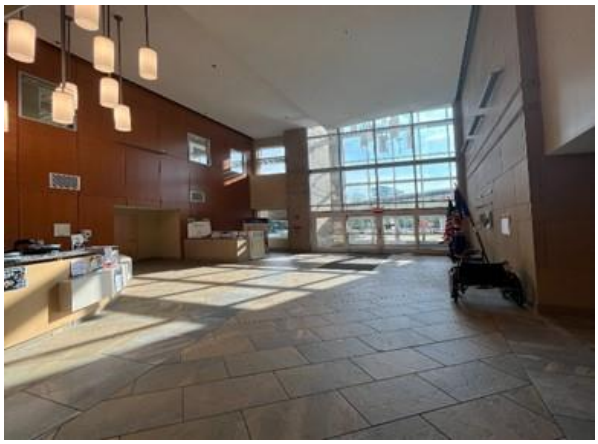


***Figure C.2.*** *Welcome Center interior.*
*Source: Photo taken by OIG inspector.*


***Figure C.3.*** *Example of tag on equipment.*
*Source: Photo taken by OIG inspector.*

# Appendix D: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: November 16, 2024

From: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio

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

Office of the Under Secretary for Health (10)

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

1. I have reviewed and concur with the response for the draft report of our Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio.
2. I concur with the responses and action plans submitted by the Chillicothe VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

*(Original signed by:)*

Laura E. Ruzick, FACHE

# Appendix E: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: November 15, 2024

From: Director, VA Chillicothe Healthcare System (538)

Subj: Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio

To: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. Thank you for the opportunity to review and comment on the draft report for the Healthcare Facility Inspection of the VA Chillicothe Healthcare System in Ohio.
2. I concur with the draft report and OIG's recommendations.
3. Comments regarding the contents of this memorandum may be directed to the Chillicothe VA Medical Center's Chief of Quality and Patient Safety.

*(Original signed by:)*

Kenneth J. Mortimer, FACHE
Executive Medical Center Director

# Appendix F: VA Responses

## Recommendation 1

The OIG recommends facility leaders ensure staff understand procedures for cleaning equipment and continue to monitor the physical separation of clean and dirty items in storage spaces.

__X__Concur

_____Nonconcur

Target date for completion: June 30, 2025

### Director Comments

The Urgent Care Nurse Manager reviewed the existing Medical Center Policy for cleaning reusable medical equipment (RME), including guidance for separation of clean and dirty items in storage spaces, via an in-service with urgent care staff in August 2024. Monthly audits are in progress to determine proper physical separation of clean and dirty items in storage spaces and reported monthly to Quality Council until compliance of 90% for six consecutive months is achieved.

The Primary Care Nurse Manager reviewed the existing Medical Center Policy for cleaning reusable medical equipment (RME), including guidance for separation of clean and dirty items in storage spaces, completing all in-service with primary care staff in by December 31, 2024. Monthly audits will be initiated by December 31, 2024, to determine proper physical separation of clean and dirty items in storage spaces and reported monthly to Quality Council until compliance of 90% for six consecutive months is achieved.

## Recommendation 2

The OIG recommends that primary care leaders incorporate feedback from primary care staff and include them in process improvement projects.

__X__Concur

_____Nonconcur

Target date for completion: June 30, 2025

### Director Comments

Primary Care leadership reviewed the existing processes for obtaining feedback from primacy care staff and including them in process improvement projects and identified opportunities to improve. Effective September 2024, frontline primary care staff representatives were included in the Primary Care All-Employee Survey Committee, Unit-Based Council, and Nursing Practice

Committee to ensure that opportunities are provided for staff to participate in process improvement projects. Primary Care staff representatives will also engage in process improvement by participating in weekly huddles and brainstorming sessions, where they can provide real-time feedback on ongoing process improvement projects.

Primary care staff will have additional opportunities to provide feedback during leader rounding conducted quarterly by Executive Leadership and monthly by Primary Care Leadership. Monthly staff meetings, weekly All-Primary care team huddles and daily service specific huddles will also serve as venues for staff to provide feedback.

By the end of the second quarter in March 2025, Primary Care staff representatives will have directly contributed to a minimum of two process improvement projects. Progress on targets will be reported monthly to Quality Council by Primary Care leadership.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Elizabeth Whidden, MS, ARNP, Project Leader<br>Veronica Leon, PhD, MSN<br>Rondina Marcelo, LCSW<br>Leslie Nash, MSN, RN<br>Kinh-Luan Nguyen, PharmD, MBA<br>Robert Ordonez, MPA<br>Laura Pond, MSW, LCSW<br>Temekia Toney, LCSW, MSW |
| **Other Contributors** | Kevin Arnhold, FACHE<br>Richard Casterline<br>Kaitlyn Delgadillo, BSPH<br>Jennifer Frisch, MSN, RN<br>LaFonda Henry, MSN, RN<br>Cynthia Hickel, MSN, CRNA<br>Christopher D. Hoffman, LCSW, MBA<br>Amy McCarthy, JD<br>Scott McGrath, BS<br>Sachin Patel, MBA, MHA<br>Ronald Penny, BS<br>Joan Redding, MA<br>Larry Ross Jr., MS<br>April Terenzi, BA, BS<br>David Vibe, MBA |

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan
Director, VA Chillicothe Healthcare System (538)

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Bernie Moreno, J.D. Vance
US House of Representatives: Troy Balderson, Dave Taylor

**OIG reports are available at www.vaoig.gov.**