US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Southern Oregon Healthcare System in White City

Healthcare Facility Inspection	24-00587-45	January 16, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Southern Oregon Healthcare System from March 4 through 7, 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. Leaders and staff identified a unique circumstance and several system shocks, which included the implementation of the new Oracle Cerner electronic health record system, executive leadership team turnover, and recruitment challenges due to the facility's rural location.[2] The OIG noted that employee satisfaction declined when the facility implemented the Oracle Cerner system.

Leaders responded to the challenges with Oracle Cerner implementation by reducing productivity goals, hiring additional staff to manage the increased workload, increasing leaders' presence in clinical and nonclinical areas, and providing staff with coping strategies to deal with

[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] In May 2018, the Department of Veterans Affairs signed a contract with Cerner to "modernize the VA's health care…system and help provide seamless care to Veterans as they transition from military service to Veteran status." "VA Signs Contract with Cerner for an Electronic Health Record System," Department of Veterans Affairs, accessed October 8, 2024, https://digital.va.gov/ehr-modernization/va-signs-contract-with-cerner-for-an-electronic-health-record-system.

stress. Leaders also addressed recruitment challenges by highlighting incentives like telework opportunities, a continuing education program, and leadership development courses.

Leaders stated staff collaborated with veteran service organizations and coordinated with the Patient Advocate to address veterans' concerns.[3] For example, volunteer service staff coordinate a monthly visit for veteran service organization representatives to meet with veterans and a monthly community breakfast attended by veteran service organization representatives and the Director.

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas, focusing on safety, cleanliness, and privacy, and compared findings from prior inspections to determine if there were areas with recurring issues.

Overall, the OIG found the environment to be clean, accessible, and easy to navigate. However, the OIG found one notable safety concern in a sitting area—a sharp edge on one of the benches—which staff immediately corrected. In addition, the OIG observed adhesive surfaces taped on walls, as well as paper items without protective coverings hanging on walls and stored in open file carts inside examination rooms. Due to the inability to clean these items, the OIG recommends that staff relocate them outside of examination rooms or use protective enclosures to mitigate the risk of infection.

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 determined facility leaders had a process to communicate urgent but noncritical test results to ordering providers and patients. This process includes a method for identifying alternative providers when the ordering provider is not available. In addition, the OIG learned that staff from the clinical nursing pool monitor view alerts for test results daily.[4] The Primary Care Clinical Operations Manager explained that the

[3] Veteran Service Organizations are non-VA, nonprofit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese, "Understanding Veterans Service Organizations Roles" (PowerPoint presentation), November 19, 2008, https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

[4] A view alert is a brief interactive electronic notification in a computerized patient record system designed to inform the user about activities. Department of Veterans Affairs Office of Information & Technology (OIT), *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, December 2023.

clinical nursing pool staff review unresolved alerts and contact the providers to determine whether they communicated the results to the patients.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[5]

The OIG found the facility had a shortage of clinical staff, which was attributed to the facility's rural location, high housing costs, limited internal promotions and virtual positions, and VHA's low salary rates for primary care positions. To address this problem, leaders broadened the pool of applicants to include intermediate care technicians to fill the licensed practical nurse role, adjusted salaries, and implemented a primary care retention incentive.

The OIG also examined panel size, which is the number of patients assigned to a primary care team. The OIG noted that leaders reduced panel sizes due to inefficiencies and problems related to the Oracle Cerner system. Leaders also established a health informatics team to work with Oracle Cerner staff to improve the system and support clinical staff.

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. Homeless program staff identified the following barriers to meeting veterans' needs: veterans' general mistrust of program staff and mental health issues. To address the barriers, staff offered a homeless lobby where veterans can receive supplies and food to establish trust, and a walk-in medical clinic for mental health care. Staff also reported relying on strong, collaborative relationships with VA, federal, state, and community partners to address challenges and ensure programs meet homeless veterans' needs.

What the OIG Recommended

The OIG recommended facility leaders relocate papers and folders outside of patient examination rooms or secure them in protective coverings to mitigate the risk of infection.

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

VA Comments and OIG Response

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

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

Abbreviations

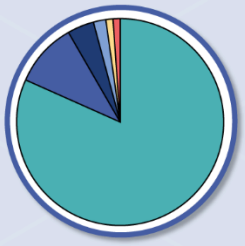
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

VA Southern Oregon Healthcare System
White City, Oregon
Level 3-Low Complexity Facility
Jackson County
Hospital Referral Region: Medford

Description of Community

RACE AND ETHNICITY



MEDIAN INCOME

$48,669

EDUCATION

90% Completed High School
57% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **279**

POPULATION

Female **303,942**
Male **297,288**
Veteran Female **5,472**
Veteran Male **48,522**

Homeless - State **17,959**
Homeless Veteran -State **1,460**

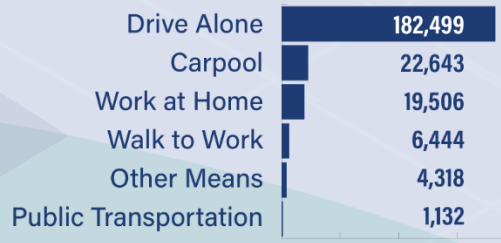
UNEMPLOYMENT RATE

7% Unemployed Rate 16+
6% Veterans Unemployed in Civilian Workforce

SUBSTANCE USE

28.6% Driving Deaths Involving Alcohol
20.5% Excessive Drinking
215 Drug Overdose Deaths

TRANSPORTATION



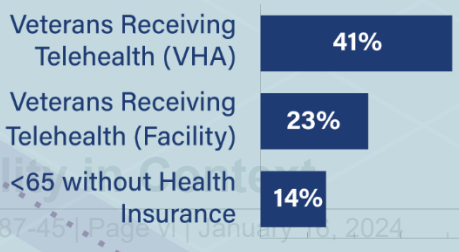
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**21 Minutes, 16 Miles**
Specialty Care	**167 Minutes, 151 Miles**
Tertiary Care	**287 Minutes, 308 Miles**

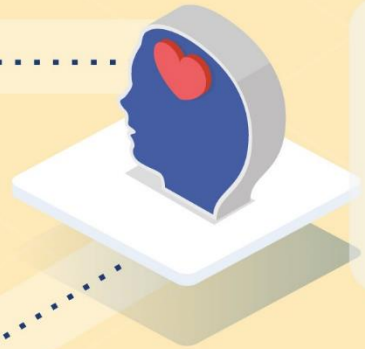
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **3,167**



Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

3,182

NA VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

NA

30-DAY READMISSION RATE

NA

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
26	50

Health of the Facility

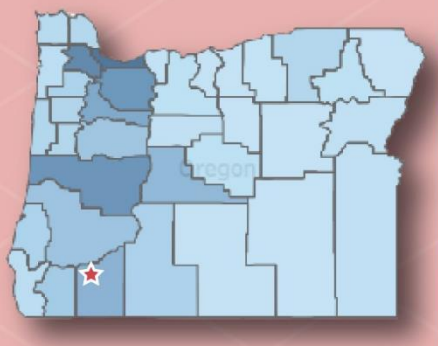
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	17K
Unique Patients VA Care	15K
Unique Patients Non-VA Care	12K

★ VA MEDICAL CENTER

VETERAN POPULATION

163 — 39,443



COMMUNITY CARE COSTS

Unique Patient $27,880	Outpatient Visit $441
Line Item $2,733	Bed Day of Care $482

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.67%
Facility Total Loss Rate	15.79%
Facility Retire Rate	2.32%
Facility Quit Rate	11.61%
Facility Termination Rate	1.74%

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

Contents

Background and Vision

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

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

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

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

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

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

High Reliability Organization Framework

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

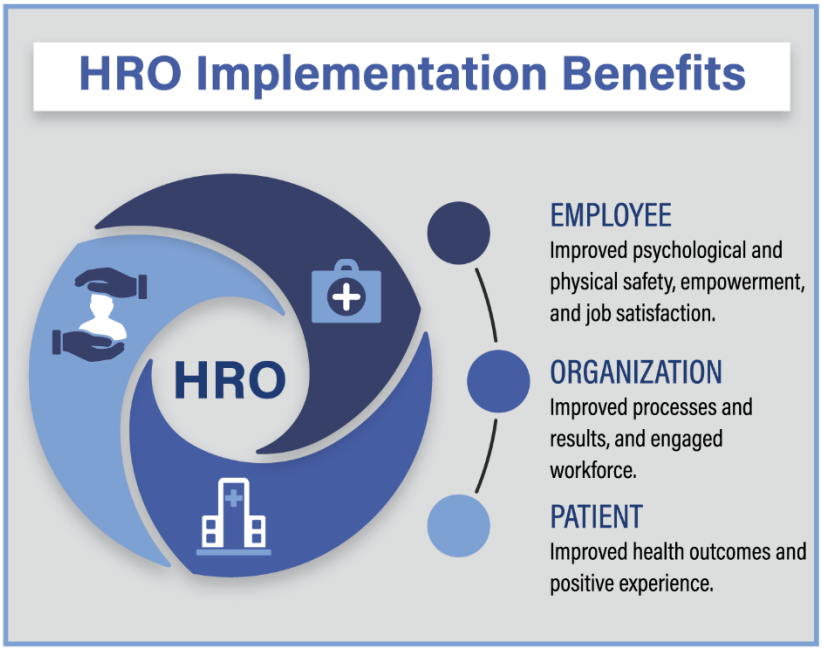


Figure 2. *Potential benefits of HRO implementation.*
Source: Departments of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7]

[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.)

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

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.

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

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

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

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

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

Content Domains

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

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

The VA Southern Oregon Healthcare System is a stand-alone mental health residential rehabilitation treatment program that started providing patient care services in 1949. At the time of the OIG inspection, the facility's executive team consisted of the Director, Chief of Staff, Associate Director, and Associate Director for Patient Care Services. Leaders told the OIG the Director was permanently assigned to the position in July 2023, the Chief of Staff in August 2023, the Associate Director in January 2023, and the Associate Director for Patient Care Services in March 2024. The facility had 120 domiciliary beds and no inpatient beds, and in fiscal year (FY) 2023, had a budget of approximately $268 million.[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]

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed October 8, 2024, https://www.va.gov/homeless/dchv.asp.

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

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus.

By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

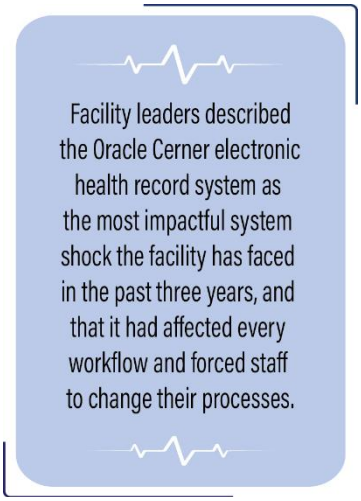


Figure 4. *Facility system shock. Source: OIG interview.*

In an interview, leaders told the OIG the June 2022 implementation of the new Oracle Cerner electronic health record system was the most impactful system shock the facility has faced in the past three years.[19] Leaders also said the facility was the first in the nation to implement the Oracle Cerner system in a residential rehabilitation treatment program, and they had lost some funding because the system was unable to accurately link services completed, such as laboratory tests, to a monetary amount.[20] Further, an organizational psychologist said that in responses to the VA All Employee Survey and exit interviews, staff listed the Oracle Cerner implementation as both their number one stressor and a significant reason for leaving the facility or considering it.[21]

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[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] In May 2018, the Department of Veterans Affairs signed a contract with Cerner to "modernize the VA's health care…system and help provide seamless care to Veterans as they transition from military service to Veteran status." "VA Signs Contract with Cerner for an Electronic Health Record System," Department of Veterans Affairs, accessed October 8, 2024, https://digital.va.gov/ehr-modernization/va-signs-contract-with-cerner-for-an-electronic-health-record-system/.

[20] "The primary goal of the MH [mental health] RRTP [residential rehabilitation treatment program] is to provide treatment and rehabilitation services to Veterans who have mental health and substance use disorders that are often complex and co-occur with medical concerns and psychosocial needs, such as employment and housing." VHA Directive 1162.02 *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

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

Most staff responses to the OIG's questionnaire also mentioned Oracle Cerner as the foremost system shock and expressed frustration with the negative effects of its implementation, such as decreased staff morale and increased stress and burnout. Facility leaders reported attempting to address the system shock by

- reducing clinician productivity goals for scheduling veterans' appointments to 70 percent of pre-implementation levels,
- hiring additional staff to manage the increased workload caused by the new system,
- routinely visiting clinical and nonclinical areas to engage with staff, and
- providing staff with coping strategies to deal with the additional stress.

The OIG questionnaire indicated that most respondents also identified turnover in executive leadership positions as a system shock. The Director added that turnover affected the facility's culture and some leaders had difficulty adjusting to the changes, which decreased morale. As previously mentioned, each member of the facility's executive leadership team was assigned in 2023, except the Associate Director for Patient Care Services who was assigned in March 2024.

Leaders discussed the facility's rural location as a unique circumstance. Specifically, leaders said that hiring clinical staff was difficult because salaries were lower in the facility's rural location compared to other medical facilities. Facility leaders requested a new locality pay scale to address this problem, but the Office of Personnel Management denied the request. Therefore, leaders offered telework opportunities, a robust continuing education program, and leadership development courses as hiring incentives to address the challenges.

Leadership Communication

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

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

[23] 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*.

[24] 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.

The OIG also reviewed questionnaire responses, which along with VA survey responses, revealed staff had mixed perceptions related to executive leader communication, transparency, and information sharing. Staff reported that leaders' communication was clear and frequent. Leaders told the OIG that barriers to effective communication between staff exist. For example, some service chiefs do not communicate directly with other service chiefs without involving executive leaders. The Associate Director stated they addressed this by publicly praising service chiefs who effectively communicate with both their staff and other leaders throughout the facility.

During interviews, an organizational psychologist described using VA survey scores to identify which staff to engage first to help leaders understand their perspectives on communication. Further, they discussed implementing several actions to sustain and improve communication:

- A daily safety meeting for service chiefs and executive leaders to promptly address needs and ensure frequent communication
- Town halls that are recorded and occurred twice a month to share information, recognize staff, and communicate HRO principles
- Weekly Director emails that highlight facility priorities
- Listening sessions in which leaders listen to staff's concerns and provide feedback on previously discussed issues
- A "coffee chat with the Director" for staff to discuss concerns one-on-one
- Quarterly safety forums in which leaders share examples of adverse safety events
- Designated change management personnel to assist leaders and staff in adapting to change and provide guidance on communication to use in the process

An organizational psychologist added that staff monitored survey scores for communication as a large component of measuring the success of these actions. Because leaders have implemented the actions above to improve communication, the OIG did not make a recommendation.

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 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.

Figure 5. *Facility workforce diversity.*
Source: Facility human resources data.

VA survey scores related to workplace diversity indicated staff believed the facility had a diverse environment; almost all measures were trending in a positive direction. However, scores also showed a 1 percent increase in staff who reported experiencing discrimination from 2022 to 2023. An organizational psychologist described a tool staff created to track and rank related VA survey scores for each department year-over-year against national averages. The manager will use the tool to identify areas where staff have reported perceived discrimination and focus on interventions for staff working in those areas.

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[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.

[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_FINAL.pdf.

Based on civilian employment data and staff onboarding information, the OIG noted the number of veterans employed in the facility was almost 2 percent below target in the last quarter of FY 2023, and there was a lower percentage of Hispanic staff compared to those in the community. Staff reported plans to increase outreach to the local Hispanic community through job fairs and advertise position vacancies in a local Hispanic magazine.

In response to the OIG questionnaire, the Equal Employment Opportunity Lead commented that executive leaders supported increased outreach to improve hiring rates for underrepresented groups, and that staff's awareness of the facility's special emphasis programs for diversity and inclusion had significantly grown. Leaders explained the facility was one of the first in the Veterans Integrated Service Network (VISN) to have a new full-time Diversity, Equity, Inclusivity, and Accessibility Manager.[29] The manager's role is to host related programs and train on topics such as unconscious bias.[30]

Leaders shared specific examples of diversity and inclusion initiatives, such as displaying a staff member's artwork in the facility to celebrate Black History Month and having staff attend a community-hosted women veterans' event to provide information about VHA. Leaders also discussed the difficulty of recruiting a diverse workforce. Specifically, the Director gave an example of at least one potential staff member who declined a clinical leadership position due to the local community's lack of racial diversity.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[31] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[32] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

[29] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Services Networks. "Veterans Integrated Services Networks (VISNs)," Department of Veterans Affairs, accessed May 21, 2024, https://www.va.gov/HEALTH/visns.asp.

[30] Unconscious bias "refers to a person's automatic attitudes about others. These biases can shape an individual's behavior towards others, especially towards people who may be of a different race/ethnicity, gender, sexual orientation, socioeconomic status, disability status, or age." "Addressing Unconscious Bias to Advance Health Equity," VA Office of Health Equity, accessed May 21, 2024, https://www.va.gov/Addressing_Unconscious_Bias_To_Advance_Health_Equity.asp.

[31] 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.

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

The facility's best places to work scores showed declining employee satisfaction in 2022, when the facility implemented the Oracle Cerner system, followed by some improvement in 2023. In an interview, leaders stated that employees' satisfaction depended on whether their work required them to use the new system. Leaders told the OIG they had taken several actions to decrease employees' stress. For example, they established a communication and feedback method for employees to troubleshoot processes within the Oracle Cerner system in real time.

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.[33] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[34] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

The OIG received questionnaire responses from one Patient Advocate and one VSO representative that revealed differing opinions about whether leaders address veterans' concerns. Specifically, the Patient Advocate indicated leaders are responsive to veterans' concerns, but the VSO representative conveyed that leaders are not responsive to concerns, with one being the lack of a Catholic chaplain at the facility.

In an interview, leaders said staff respond directly to veterans' complaints in coordination with the Patient Advocate. Leaders also discussed the facility's ongoing coordination with VSOs through the facility's volunteer service. Volunteer service staff coordinate a monthly visit for VSO representatives to meet with veterans who are in the rehabilitation program and a monthly community breakfast attended by VSO representatives and the Director.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[35] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 6. *Facility photo. Source: "White City VA Medical Center," Department of Veterans Affairs, accessed May 21, 2024, https://www.va.gov/southern-oregon-health-care/locations.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[36] 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.[37]

[35] VHA Directive 1608(1).

[36] 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.

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

Transit and Parking

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

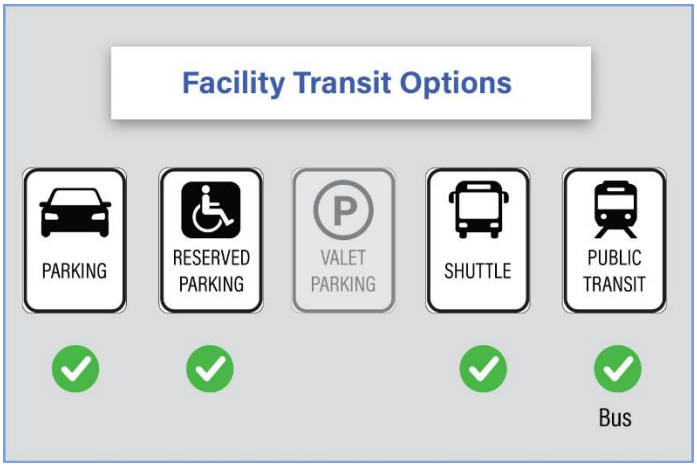

Figure 7. *Transit options for arriving at the facility. Source: OIG analysis of documents and observations.*

The OIG inspection team used navigation links located on the facility's website and a phone application to obtain directions. Using both links, the team navigated to the facility without difficulty. Because the facility includes a rehabilitation center and clinics in different buildings, there is no single designated building entrance, and signage does not identify a main entrance.

Throughout the inspection week, the OIG observed available parking with spaces accessible for people with disabilities. The parking lots also had adequate lighting, pathways, and police alarm call buttons for veterans to use in case of emergencies. There were multiple bus stops around the campus with clear signs showing bus routes and schedules, as well as overhead canopies to shelter veterans. Based on these observations, the OIG found the facility's transit and parking to be adequate.

Main Entrance

Figure 8. *Building 201-A entrance. 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.[38]

While the facility does not have a designated main entrance, the OIG observed that most veterans used primary care building 201-A as the main entrance. Primary care buildings 201 and 201-A were adjacent to each other. The OIG noted that building 201's entrance was accessible by ramp and building

[38] 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*.

201-A's entrance was level with the outdoor sidewalk, making stairs or a ramp unnecessary. Both entrances had power-assisted doors and extended ceilings above the doors, offering sheltered areas for veterans entering the buildings.

Building 201-A's entrance area was clean and spacious, with panoramic windows that provided natural lighting. Further, there were smooth transitions from carpet to flooring that did not pose tripping hazards for veterans using assistive devices. The space included an information desk with volunteers, multiple wheelchairs, and a sitting area for veterans to socialize.

The OIG team observed a sharp edge on one of the benches in the sitting area that could potentially cause harm; however, staff promptly repaired the bench before the team left the area. The OIG's overall impression was of a clean and welcoming space.

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.[39]

The OIG noted adequate information, such as up-to-date and color-coded printed maps at the information desk in building 201-A. The OIG observed volunteers escorting veterans or providing directions to appointment locations. The OIG also observed signage that listed building numbers and identified service locations. The OIG easily found locations using navigational cues.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[40] The OIG observed detectable changes in

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

[40] 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; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

flooring, automatic front doors, and braille outside the elevators to assist visually impaired veterans.[41] Although there were no audio instructions, the OIG noted that veterans generally did not have to navigate independently because volunteers and staff promptly helped them get to their desired destination.

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.[42]

The facility had two toxic exposure screening navigators, both serving in the role as a collateral duty. The OIG interviewed the lead navigator, the Deputy Chief of Staff, and the acting Deputy Associate Chief of Staff Primary Care, who described the facility's screening and referral processes. The navigator said staff screen approximately 90 percent of veterans during primary or specialty care visits, and the rest are screened during community care appointments.[43] The navigator indicated that either licensed independent practitioners or social work, pharmacy, or nursing staff screen veterans at the facility; if a clinician other than a licensed independent practitioner screens veterans who indicate they have been exposed to toxins, a licensed independent practitioner performs a secondary screening. A licensed independent practitioner may also refer veterans for navigator appointments to answer additional questions associated with the screenings.

The Deputy Chief of Staff reported challenges with referring veterans for navigator appointments due to Oracle Cerner system issues. In response, staff developed workarounds involving relabeling referrals in the system or processing referrals with alternative methods outside the system. For example, staff relabeled referrals by renaming existing appointments to *between-visit encounters*, so the system would not require a billable charge to close the referral. Alternative methods included using the facility's message center or emailing a copy of the chart note for navigators' in-depth review and patient discussion.

Additionally, the Deputy Chief of Staff conveyed that facility staff conducted three toxic exposure screening outreach events in the year prior to the OIG visit and scheduled four outreach

[41] "Detectable warnings are a distinctive surface pattern of domes detectable by cane or underfoot that alert people with vision impairments of their approach to street crossings and hazardous drop-offs." US Access Board, (Proposed) Public Right-of-Way Accessibility Guidelines, *Detectable Warnings Update*, March 2014, accessed April 3, 2024, https://www.access-board.gov/prowag/other/dw-update.html.

[42] 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.

[43] Community care is defined as veterans receiving healthcare through community providers when VHA is unable to provide the services needed. "Community Care," Department of Veterans Affairs, accessed May 21, 2024, https://www.va.gov/communitycare/.

activities in FY 2024. The OIG noted flyers promoting the outreach events at the information desk in building 201-A. Additionally, the lead navigator reported no access, space, or wait-time barriers to screenings.

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

The OIG reviewed the facility's most recent OIG comprehensive healthcare inspection report, published in December 2019, and noted no recommendations involved the environment of care. During an interview, the Chief, Facility Management Service stated that the top three deficiencies identified during environment of care inspections in FY 2023 were dirty floors, stained or missing ceiling tiles, and damaged walls, which the OIG confirmed staff had documented in the deficiency reports. The chief also described completing a performance improvement plan to mitigate the issues noted above and added that staff report findings quarterly to the Safety and Health Leadership Committee. Leaders said facility management service staff proactively identify issues and fix them rather than wait for scheduled environment of care inspections. They also educate unit staff on how to identify and report deficiencies.

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 primary care clinic areas and the residential rehabilitation treatment program area and observed that the facility was generally clean and well maintained. The OIG observed clear exit paths, patients able to move freely, and no visible protected patient information. However, at the three primary care clinic areas, the OIG noted sticky mats (surfaces designed to adhere paper notices) taped on walls and papers and folders hanging on walls or stored in open file carts in multiple patient examination rooms. The papers and folders were not in protective coverings, which prevents proper cleaning and poses an infection risk. The OIG

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

recommends facility leaders relocate papers and folders outside of patient examination rooms or secure them in protective coverings to mitigate the risk of infection.

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.[45] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[46] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG found that leaders had established processes for informing ordering providers about urgent, noncritical abnormal test results and for delegating responsibility for following up on the results with patients. Staff assign a qualified designee as an alternative provider if the ordering provider is unavailable. For breast imaging and cervical screenings, there is a reporting process to communicate abnormal test results to ordering providers within specific time frames.

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

[46] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

Action Plan Implementation and Sustainability

Figure 10. *Status of prior OIG recommendations. Source: OIG analysis of documents.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[47] 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 no open recommendations from previously published OIG reports aimed at enhancing the communication of test results. The Patient Safety Manager reported using the Joint Patient Safety Reporting system to monitor safety events related to the communication of test results.[48] When staff identify trends in patient safety issues, they conduct root cause analyses and share the results with appropriate committees, teams, and in other venues to improve processes.[49] The Patient Safety Manager denied facing any challenges with employee participation or leaders' support for root cause analyses or other investigations involving test result communication.

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.[50] 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.[51] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG learned that clinical nursing pool staff monitor view alerts for test results daily.[52] The Primary Care Clinical Operations Manager reported that clinical nursing pool staff review any

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

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

[49] The root cause analysis is a process used for staff to identify the underlying cause of system failures. VHA National Center for Patient Safety, *Guide to Performing a Root Cause Analysis*, February 5, 2021.

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

[51] VHA Directive 1050.01(1).

[52] A view alert is a brief interactive electronic notification in a computerized patient record system designed to inform the user about activities. Department of Veterans Affairs Office of Information & Technology, *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, December 2023.

unresolved alerts and contact the providers to confirm if they communicated the results to the patients.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[53] 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.[54] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[55] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG found the facility's 12 primary care teams had several vacancies: four full-time clinical associates (a combination of licensed practical nurse and intermediate care technician roles), one registered nurse care manager, one primary care provider, and five social workers. Primary care team members explained that staffing shortages disrupted their workflow, and that registered nurses took on responsibilities of the clinical associates, which delayed them in responding to secure messaging from veterans.

Leaders conveyed that factors, such as the facility's rural location, costly housing market, limited internal promotion opportunities and virtual positions, and lower pay for positions in primary care compared to specialty care caused challenges with recruiting licensed practical nurses and social workers. Leaders also said that to address the licensed practical nurse vacancies, leaders broadened the pool of applicants to include intermediate care technicians to fill the role. To retain nurses in primary care, leaders stated they recently increased the licensed practical nurse salary and offered a retention incentive.

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

[54] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2034* (Washington, DC: Association of American Medical Colleges, June 2020).

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

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[56] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[57]

Leaders intentionally reduced providers' expected number of patients seen per day from 12–13 to 9 to reduce each team's workload. Primary care staff said this decision resulted primarily from barriers created by the Oracle Cerner system, such as slow system connectivity, lag times, loss of information due to system updates, and staff's increased stress due to repetitive tasks and cumbersome documentation processes. In an interview, a primary care provider said that despite the panel size adjustments, it would be unrealistic for leaders to increase the panel size above the current level without correcting the Oracle Cerner problems.

Primary care staff told the OIG that approximately 50 percent of incoming patient phone calls were routed to a queue with lengthy wait times at a centralized call center in Portland, which significantly delayed timely follow-up from clinicians. The OIG reviewed committee meeting minutes that validated patients' difficulty communicating with primary care staff was one of the top three complaints. Leaders acknowledged being aware of the issue and working toward a resolution.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Despite the challenges discussed above, the OIG found that leaders were committed to improving efficiency in primary care. Leaders indicated they also focused on developing effective recruitment strategies to build teams and continue to achieve the VA mission.

Facility leaders reported being attentive to the Oracle Cerner system challenges and committed to improvement. They recognized the need for more technical support to address hundreds of unresolved help desk tickets and elevated concerns at VISN and national levels. Leaders added that they recently established an internal health informatics team to work closely with Oracle Cerner staff to make effective system improvements, develop new employee training, and provide direct support to clinical staff.

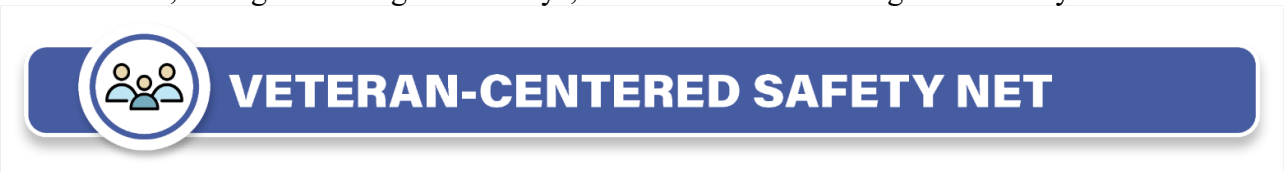
[56] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[57] VHA Directive 1406(1).

[58] VHA Handbook 1101.10(2).

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 that PACT Act implementation had not increased veteran enrollment rates at the facility; however, it has affected primary care staff who conduct toxic exposure screenings. A primary care provider told the OIG the screenings have significantly increased time spent in appointments and suggested staff schedule screenings as separate encounters. The Registered Nurse Care Manager added that the Oracle Cerner system did not allow staff to extend primary care appointment times to screen veterans for toxic exposure when indicated. The OIG reviewed data on new patient appointment wait times, noting the average was 9 days, which is below VHA's goal of 20 days.



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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[59]

Identification and Enrollment of Veterans

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

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

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

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

The facility's HCHV program did not meet the HCHV5 target in FYs 2021 through 2023. However, the metric significantly improved from 61.6 percent in FY 2021 to 94.5 percent in FY 2023. The Program Coordinator explained that staff were close to meeting the 100 percent goal; however, they inadvertently failed to account for some unsheltered veterans who should have received a program intake assessment. The coordinator attributed the lower percentages in FYs 2021 and 2022 to challenges related to the COVID-19 pandemic. Further, the coordinator said staff did not consider the point-in-time count to be an accurate reflection of the unsheltered veteran community because the count took place during the winter, and homeless people are often not seen outside in inclement weather.

The coordinator explained that HCHV staff visit shelters, hospitals, community agencies, and encampments; conduct street outreach; attend community resource fairs that target homeless citizens; educate community partners and veterans on VA services; and enroll veterans in the HCHV program. The coordinator shared that staff communicate regularly with community police and the sheriff's office and attend community meetings, such as the Jackson County Homeless Task Force, Medford Police Department Chronically Homeless Outreach Program, and Medford Department Livability Team, to learn about veterans in need.

The coordinator reported two barriers in identifying and enrolling veterans in the program: veterans' general mistrust of program staff and mental health issues that limit their engagement with VA services. To establish trusting relationships, the coordinator described setting up a homeless lobby at the facility, which offered veterans phone chargers, hygiene supplies, nonperishable food items, clean clothes, and a place to rest. The homeless lobby also provided staff an opportunity to discuss VA services with veterans and enroll them into the homeless program.

To address the mental health challenges of homeless veterans, the facility offered a walk-in medical clinic to veterans not enrolled in primary care. The coordinator identified that the lack of a mental health crisis or detox unit hindered staff's ability to assist patients with acute mental health needs.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due

to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[62]

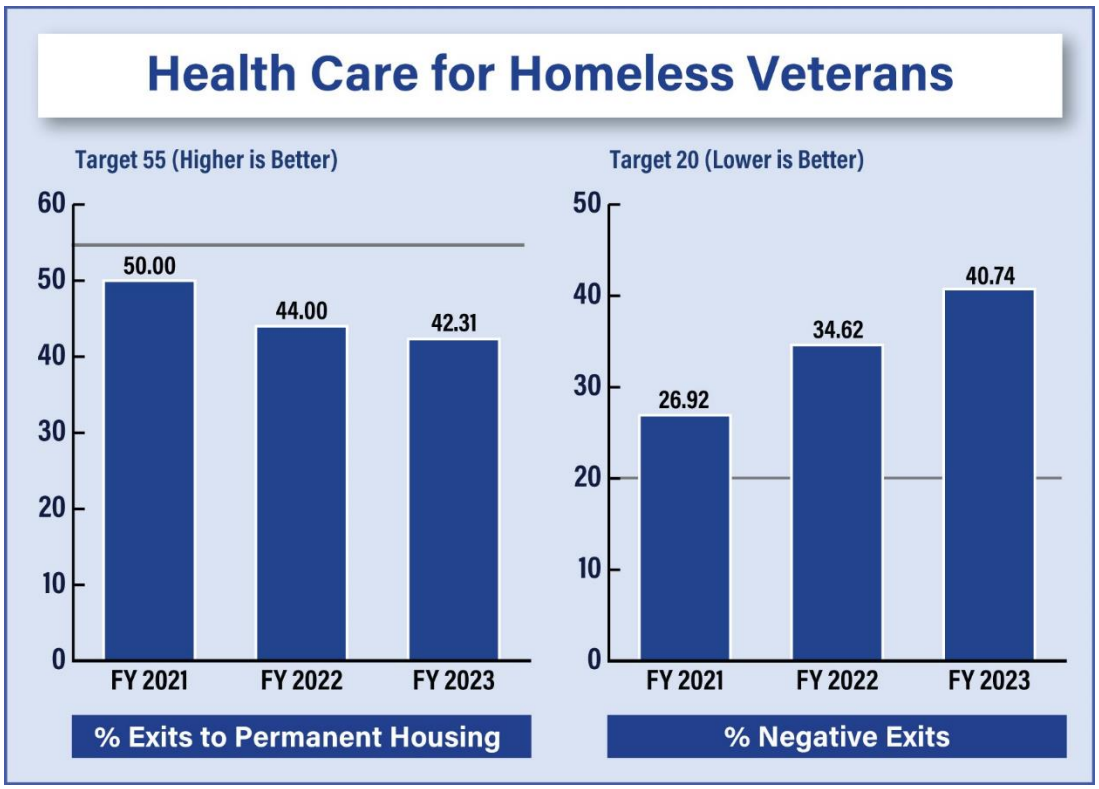

Figure 11. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program did not meet the HCHV1 target in FYs 2021 through 2023. The program coordinator said the metric did not accurately reflect staff's efforts to reduce homelessness due to the limited affordable housing options in the area. Notably, a fire in October 2020 had destroyed over 2,000 homes that were mostly low-income housing.

The coordinator also cited other barriers to meeting the needs of local homeless veterans, including limited resources for veterans who have difficulties with activities of daily living, complex mental health issues, prior evictions or who are registered sex offenders, and those with limited income.[63] To mitigate these barriers, staff collaborated with the Veterans Benefits Administration, VSOs, and the Department of Health and Human Services to access resources.

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

[63] Activities of daily living are daily self-care activities, such as bathing, dressing, and eating. VHA Directive 1141.03(1), *VA Operated Adult Day Health Care*, November 9, 2020, amended January 3, 2024.

The Homeless Program Manager described the Oracle Cerner system problems as involving a cumbersome referral process that caused medical record documentation errors. For example, program staff said that to use the system to refer homeless veterans to the vocational rehabilitation program, they had to indicate veterans received a physical exam even if they had not. Program staff also reported that Oracle Cerner system had limited view alert capability that could lead to missed referrals of homeless veterans for VA services.

The program also failed to meet the HCHV2 targets for FYs 2021 through 2023. The Homeless Program Manager explained that challenges with reducing the number of negative exits included veterans' difficulty adjusting to a communal living setting and ongoing substance use. To address these challenges, the manager said program staff attempt to locate and re-engage veterans who left without consulting staff and refer veterans to substance use treatment that best meet their individual needs.

The manager also said that facility leaders support the HCHV program. For example, when VHA changed a national policy and disallowed funding for meals in the homeless lobby, the facility Director provided discretionary funds for packaged foods to be offered there. The program coordinator shared a success story about a homeless veteran discharged from a community hospital with a communicable infection. The coordinator recognized the veteran's need for isolation and medical care that was not available at the facility or in homeless shelters, so staff arranged for admission to a program in a neighboring state to meet the veteran's needs.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[64] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[65]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[66] The facility's Veterans Justice Program did not meet its expected target for veteran enrollment in FY 2023. The program coordinator said the biggest barrier to meeting this target was lack of adequate staffing in the prior 18 months. However, leaders had

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

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

[66] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

filled the two licensed clinical social worker vacancies by February 2024, and the coordinator described feeling confident the program could now meet the target.

The Veterans Justice Program covered four counties, which together contained four jails, one prison, one work center, and one veterans treatment court.[67] The program coordinator explained that jail and prison staff notified the program team about every veteran entering the jail or prison system either by encrypted email or fax. If veterans' substance abuse or mental health issues contributed to the crimes they committed, and they meet other qualifiers, the treatment court can provide a variety of supportive services from the VA and local community. Once identified, the program coordinator sets up a call with the incarcerated veterans to assess their needs.

Meeting Veteran Needs

The program coordinator reported building strong relationships within the facility and externally to advocate for enrolled veterans. The program coordinator described establishing ties with judges in the veterans treatment court and supporting veterans by often finding innovative solutions, such as telehealth appointments from neighboring states, to provide needed services. The program coordinator emphasized that limited mental health treatment capacity both at the facility and in the community can be a barrier to meeting veterans treatment court requirements for ongoing mental health care and provider oversight.

When necessary, the program coordinator collaborates with and connects veterans with community resources outside the VA, such as state healthcare plans. The program coordinator described maintaining a positive rapport with the facility's residential rehabilitation treatment program admissions staff to expediently transfer veterans from jail to the program.

The program coordinator said that staff track enrolled veterans in the Homeless Operations, Management, and Evaluation System database, and they recently started tracking non-clinical activities performed with judicial and community partners in the Administrative Data Tracking System.[68] The OIG found that program staff were knowledgeable about community resources,

[67] Veterans treatment courts integrate "evidence-based substance use disorder treatment, mandatory drug testing, incentives and sanctions, and recovery support services in judicially supervised court settings that have jurisdiction over veterans involved in the justice system who have substance use disorders." "Veterans Treatment Court Program," Bureau of Justice Assistance US Department of Justice, accessed October 15, 2024, https://www.bja.ojp.gov/program/veterans-treatment-court-program/overview.

[68] "The Administrative Data Tracking System (ADTS) is available in HOMES [Homeless Operations, Management, and Evaluation System] to provide the ability for VJP [Veterans Justice Program] and HVCES [Homeless Veterans Community Employment Services] staff with reporting-level access to document non-clinical activities that help develop, maintain, or expand programs/services locally, including projects and presentations that are often coordinated with judicial and community partners." VA Office of Analytics and Operational Intelligence–Homeless Program Office, *VHA Homeless Programs Quick Guide: Administrative Data Tracking System (ADTS)*, December 8, 2020.

engaged with community and local partners, and tracked outreach efforts to provide needed services.

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."[69] 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.[70]

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).[71] The program did not meet the target for FYs 2021 through 2023. In an interview, the program supervisor attributed this to lack of adequate program staffing, limited affordable housing options, and veterans' failure to obtain documents required by housing authorities.

The program supervisor listed at least five vacancies in the program: a housing specialist, social worker, senior social worker, peer specialist, and intake supervisor. The Chief of Social Work said that social worker vacancies were attributable to the facility's salaries being lower than those in other nearby VA facilities. Staff shared that the program was unable to use hiring incentives, such as student loan repayment and relocation assistance, because those funds were allocated to social worker positions in other departments. The program supervisor added that the cost of living was high compared to the salaries offered in the local area, making the income-to-rent ratio disproportionate, which created challenges recruiting program staff.

The program supervisor reported that housing availability decreased due to the fire that destroyed homes in 2020 and the COVID-19 pandemic, which enabled individuals to rent homes longer using emergency COVID-19 funds. The program supervisor added that the cost of rental homes had risen above the voucher limit in one county.

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

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

[71] 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*.

In an interview, the OIG learned that veterans wanting to be enrolled in the program were required to meet the counties' housing authority criteria and participate in case management. The program supervisor shared that variations among the housing authority requirements, including what documents veterans must submit, were outside staff's control and could delay program enrollment. To address the issue, program staff maintained collaborative relationships with housing authorities to ensure they understood the requirements and could reduce or prevent delays.

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).[72] The program met the target for FYs 2021 through FY2023. The Chief of Social Work attributed this to the dedication and resourcefulness of the program's Homeless Veteran Community Employment Coordinator. The program supervisor explained that staff collaborated with community partners to help veterans maintain stable housing and employment through services, such as property inspections; wellness checks; and case management for psychosocial, medical, financial, and general living needs.

The Housing and Urban Development–Veterans Affairs Supportive Housing program staff shared a success story about a veteran who was on the autism spectrum, had not worked for many years, and obtained federal employment. Program case managers helped the veteran improve communication, while the Homeless Veteran Community Employment Coordinator walked the veteran through the process of applying for federal employment.

Figure 12. *A program success story.*
Source: OIG interview.

The program supervisor shared that veterans lost housing due to a state law that allowed landlords to evict tenants without cause in the first year of a lease agreement. To assist these evicted veterans, the program supervisor highlighted collaboration with other resources, such as the Grant and Per Diem Program, to provide housing.[73] The program supervisor also identified that there were limited housing options available for aging veterans with disabilities. Although the program supervisor did not provide a solution to these challenges, the OIG learned that staff conduct outreach to community medical and social services, housing authorities, and various landlords and property managers to strengthen or develop new relationships to meet veteran needs.

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

[73] "Since 1994, GPD [Grant and Per Diem Program] has awarded grants to community-based organizations to provide transitional housing with wraparound supportive services to help vulnerable Veterans move into permanent housing." VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report,* https://www.va.gov/VA-Homeless-2022-HPO-Annual-Report-508c.pdf.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided a recommendation on a systemic issue that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's finding and recommendation 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.

Minor

Finding: Multiple patient examination rooms had sticky mats taped on walls and papers and folders hanging on walls or stored in open file carts with no protective coverings, which prevents proper cleaning.

Recommendation 1: The OIG recommends facility leaders relocate papers and folders outside of patient examination rooms or secure them in protective coverings to mitigate the risk of infection.

Appendix A: Methodology

Inspection Processes

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from March 4 through 7, 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.

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

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

[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.

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

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.

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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 13, 2024

From: Director, VA Northwest Health Network (10N20)

Subj: Healthcare Facility Inspection of the VA Southern Oregon Healthcare System in White City

To: Director, Office of Healthcare Inspections (54HF01)

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

1. Thank you for the opportunity to provide a response to the finding from the draft report, Healthcare Facility Inspection of the VA Southern Oregon Healthcare System in White City.
2. I concur with the recommendations and will ensure that corrective actions are completed as described.

(Original signed by:)

Teresa D. Boyd

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 11, 2024

From: Director, VA Southern Oregon Healthcare System (692)

Subj: Healthcare Facility Inspection of the VA Southern Oregon Healthcare System in White City

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Healthcare Facility Inspection of the VA Southern Oregon Healthcare System in White City.
2. I concur with the finding and recommendation and will ensure that actions to correct these findings are completed as described in responses to the draft report.

(Original signed by:)

Richard A. Skiff
Acting Medical Center Director

Appendix E: VA Responses

Recommendation 1

Facility leaders relocate papers and folders outside of patient examination rooms or secure them in protective coverings to mitigate the risk of infection.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2025

Director Comments

The VA SORCC [VA Southern Oregon Rehabilitation Center and Clinics] will secure the papers in Building 201 and 201 A exam rooms in protective coverings. A work order was submitted on December 9, 2024, and photographic evidence anticipated to be submitted by January 31, 2025.

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