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

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the VA Western New York Healthcare System in Buffalo

| Healthcare Facility Inspection | 24-00597-22 | January 8, 2025 |
|---|---|---|


## OUR MISSION

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

## CONNECT WITH US

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

## PRIVACY NOTICE

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

# Executive Summary

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

## What the OIG Found

The OIG physically inspected the VA Western New York Healthcare System during the week of April 22, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed. The OIG made no recommendations for improvement.

### 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. Executive leaders identified weather as a recent system shock, when the Buffalo area experienced a four-day blizzard over the Christmas season in 2022. The blizzard produced six feet of snow and took several days to clear. Leaders reported learning many lessons (having additional staff, supplies, and food) from the event and employing them when a snowstorm affected the Buffalo area in 2023, available prior to the storm.

Overall, the facility's All Employee Survey scores increased over the past few years.[2] Leaders attributed the increases to continuous improvement, consistent communication, transparent information, and the use of high reliability organization principles. Leaders used a variety of

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

[2] The 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.

methods to share information, including town halls, patient safety forums, newsletters, messaging boards, and visits to clinical and nonclinical areas.

All Employee Survey scores for best places to work, no fear of reprisal, and supervisor trust improved from fiscal years 2022 to 2023. Leaders attributed the increase to believing in the VA mission and supporting employees. Leaders also focused on promoting high reliability organization principles through education, as well as challenging employees to question processes and facility operations, adding that they believed employees felt empowered to make suggestions to improve the culture and report patient safety events. Leaders prioritized diversity and inclusiveness and recognized the importance of making sure employees feel fulfilled in their work and knowing they are an important part of the team.

Regarding veteran experiences at the facility, the Patient Advocate reported the three most common complaints were about care in the community billing, staff communication delays, and lack of education from providers.[3] Veteran service organization questionnaire respondents identified length of time to get appointments, lack of promised call-backs from staff, practitioner availability for specialty care, and lack of parking during busy hours as the most common veteran complaints.[4] Leaders stated they reviewed patient advocate reports and met quarterly with veteran service organizations to address any concerns. Veterans service organizations reported leaders were generally responsive to them and the veterans' concerns.

## Environment of Care

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

[3] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[4] Veteran service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf. During the executive leadership interview, the Chief of Staff reported on challenges in recruiting specialty care providers including hematology-oncology, neurology, and gastroenterology. The facility reported longer wait times for these specialty services and noted the availability and use of community care services. The OIG team (Team A) was aware a separate OIG team (Team B) was addressing allegations of delay in community care and concerns with facility leaders' failure to resolve these delays; therefore, Team A did not further explore these issues. In August 2024, the Executive Director and the Chief of Staff were transferred out of their positions pending results of an investigation related to failures in addressing delays in community care. On September 27, 2024, the OIG published a report detailing the results of Team B's inspection, VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, Report No. 23-03679-262. "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

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

The OIG inspected several clinical and nonclinical areas and found the facility to be clean and well-maintained, with ample parking. Although veterans and visitors entered the facility through a slightly confined space, the OIG found the facility to be open; have multiple spaces for gatherings and events; and easily navigable using maps, wall-mounted signs, and programmable screens.

The OIG reviewed the facility's processes for conducting toxic exposure screenings, as required by the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act and found facility staff had conducted approximately 27,000 initial toxic exposure screenings between August 10, 2022, and April 19, 2024, and hosted 11 PACT Act outreach events to educate veterans about benefits.[5] Staff stated the program would benefit from a dedicated full-time administrative assistant to help with tasks, such as calling veterans for follow-up appointments.

The OIG found the facility exceeded VHA's performance target for closing identified environment of care deficiencies or creating action plans to address them within 14 business days, and for leaders attending environment of care rounds. During the general inspection, the OIG noted facility staff inspected medical equipment; protected patient information; complied with requirements for storing expired, damaged, and contaminated medications; identified biohazard waste; and restricted access to supply rooms, as required. The OIG did not identify any repeat findings.

## Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility had processes and policies for communication of abnormal test results to ordering providers and identification of surrogate providers when needed. However, the Chief of Staff acknowledged the current processes needed improvement when ordering providers and surrogates were unavailable, and the facility updated their policies in September 2024. The OIG found staff performed quarterly internal audits that did not identify any major delays in test result notifications. After providers identified alert

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

fatigue from view alerts (test result notifications), the Chief of Staff began evaluating new processes to reduce the number of alerts received.[6]

The Chief of Staff and quality management staff explained that executive leaders supported improvement projects, and quality management staff educated staff about process improvements. The facility had no open or closed recommendations related to the communication of test results.

## 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 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.

Although the facility reported a shortage of administrative assistants, the OIG found patients did not experience increased appointment wait times or delays in care. The OIG found the facility's panels were not full. Facility leaders had created a new primary care team and hired additional staff in anticipation of increased patient enrollment due to the PACT Act. However, enrollment decreased, which leaders attributed, in part, to patients relocating to warmer climates. In response, when providers leave the facility, leaders plan to reassign patients to available providers to improve panel fullness. Leaders also stated they were conducting outreach events and using social media to increase enrollment.

Primary care team members said they routinely assess patients' care needs and divert those with high care assessment needs scores to a care coordination and integrated case management team that provides intensive case management until the patient meets their individualized goals. Regarding process improvements, primary care nurses identified that they did not address view alerts from patient calls during clinic hours so they implemented a process to divert view alerts and calls to a telephone triage system, where patients could immediately access someone for urgent concerns or leave a message for their primary care nurse for non-urgent concerns. Primary care nurses reported this process change successfully decreased workload and improved workflow within their teams.

## 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. Veterans Justice Program staff served six veterans treatment courts and 15 jails and prisons within the

[6] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

facility's seven-county service area and conducted over 60 outreach and educational events from fiscal year 2021 through fiscal year 2023.

The OIG found the facility had an active homeless program and staff worked closely with community partners in identifying homeless veterans and providing them services and resources. Health Care for Homeless Veterans leaders explained that program staff collaborated with facility mental health, suicide prevention, and primary care staff, who frequently asked them to identify veterans in need of follow-up health care. In response, program staff developed a mobile outreach team who provided non-emergency interventions to veterans otherwise lost to care. On September 1, 2016, the United States Interagency Council on Homelessness recognized the facility's homeless program, their community partners, and local leaders in ending homelessness in four cities (Buffalo, Niagara Falls, Tonawanda, and Lockport); and five counties (Erie, Niagara, Orleans, Genesee, and Wyoming).

## VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes D and E for the full text of the directors' comments). No further action is required.

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

# Abbreviations

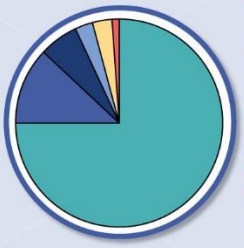
| | |
|---|---|
| FY | fiscal year |
| HCHV | Health Care for Homeless Veterans |
| HRO | high reliability organization |
| OIG | Office of Inspector General |
| PACT | Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics |
| VHA | Veterans Health Administration |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

# FACILITY IN CONTEXT

**VA Western New York Healthcare System**
**Buffalo, New York**
Level 1b-High Complexity
Erie County
Hospital Referral Region: Buffalo

## Description of Community

### RACE AND ETHNICITY




### MEDIAN INCOME

**$56,141**

### EDUCATION

**91%** Completed High School
**61%** Some College

### VIOLENT CRIME

Reported Offenses per 100,000 **221**

### POPULATION

Female **1,213,520**
Male **1,156,120**
Veteran Female **11,383**
Veteran Male **119,856**

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

### UNEMPLOYMENT RATE

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

### SUBSTANCE USE

**23.5%** Driving Deaths Involving Alcohol
**21.3%** Excessive Drinking
**793** Drug Overdose Deaths

### TRANSPORTATION

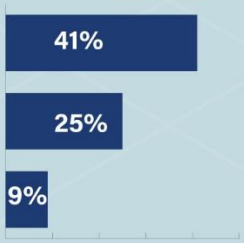

### AVERAGE DRIVE TO CLOSEST VA

| | |
|---|---|
| Primary Care | **18.5 Minutes, 13.5 Miles** |
| Specialty Care | **52.5 Minutes, 48.5 Miles** |
| Tertiary Care | **74 Minutes, 68 Miles** |

## Access to Health Care

### ACCESS

VA Medical Center Telehealth Patients 12,344



# Health of the Veteran Population

**VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY**

**8,991**

**144** VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

**AVERAGE INPATIENT HOSPITAL LENGTH OF STAY**

**5.84** Days

**30-DAY READMISSION RATE**

**12%**

## SUICIDE RATE PER 100,000

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

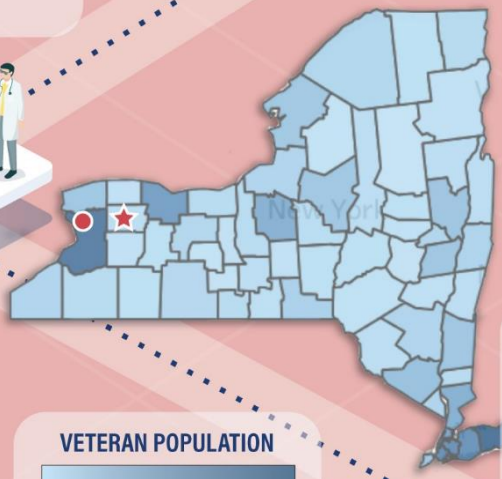
# Health of the Facility


## UNIQUE PATIENTS

| | |
|---|---|
| Unique Patients VA and Non-VA Care | 56K |
| Unique Patients VA Care | 53K |
| Unique Patients Non-VA Care | 11K |

## COMMUNITY CARE COSTS

| | |
|---|---|
| Unique Patient $18,392 | Outpatient Visit $667 |
| Line Item $1,741 | Bed Day of Care $330 |



## STAFF RETENTION

| | |
|---|---|
| Onboard Employees Stay <1 Yr | 11.81% |
| Facility Total Loss Rate | 12.79% |
| Facility Retire Rate | 2.51% |
| Facility Quit Rate | 9.13% |
| Facility Termination Rate | 1.02% |

**VETERAN POPULATION**

466 — 56,446

★ Buffalo VA Medical Center

● Batavia VA Medical Center

The VA Western New York Healthcare System includes the Buffalo VA Medical Center in Buffalo, NY and Batavia VA Medical Center in Batavia, NY. The OIG visited the Buffalo VA Medical Center.

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

# Contents

# Background and Vision

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

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

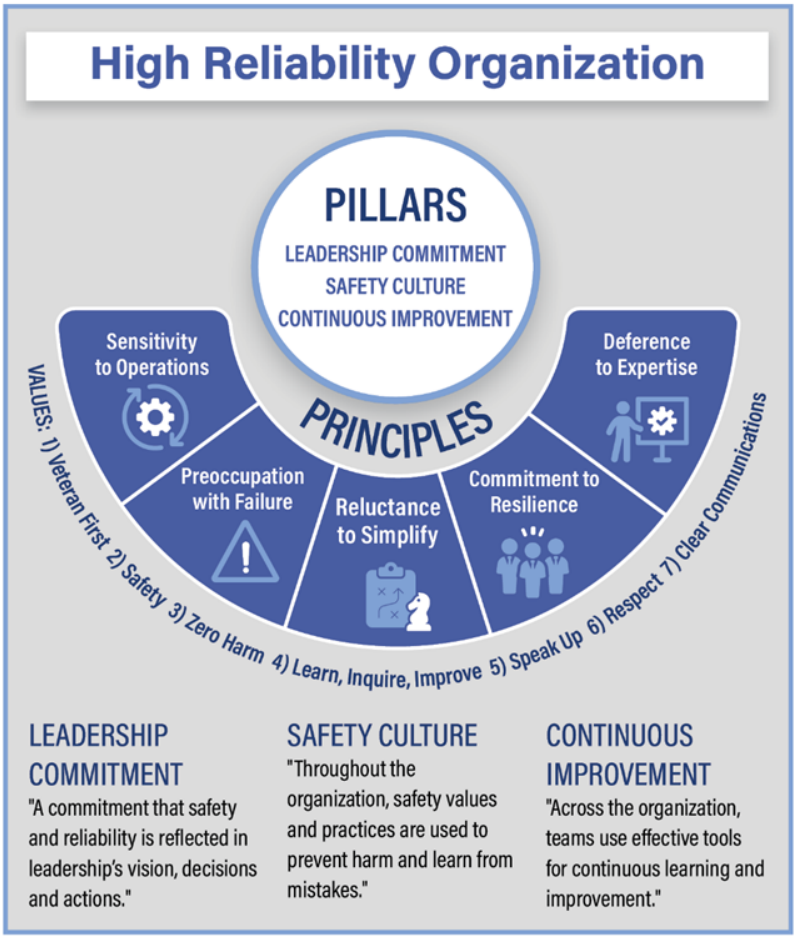



***Figure 1.*** *VHA's high reliability organization framework.*
*Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

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

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

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

## High Reliability Organization Framework

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

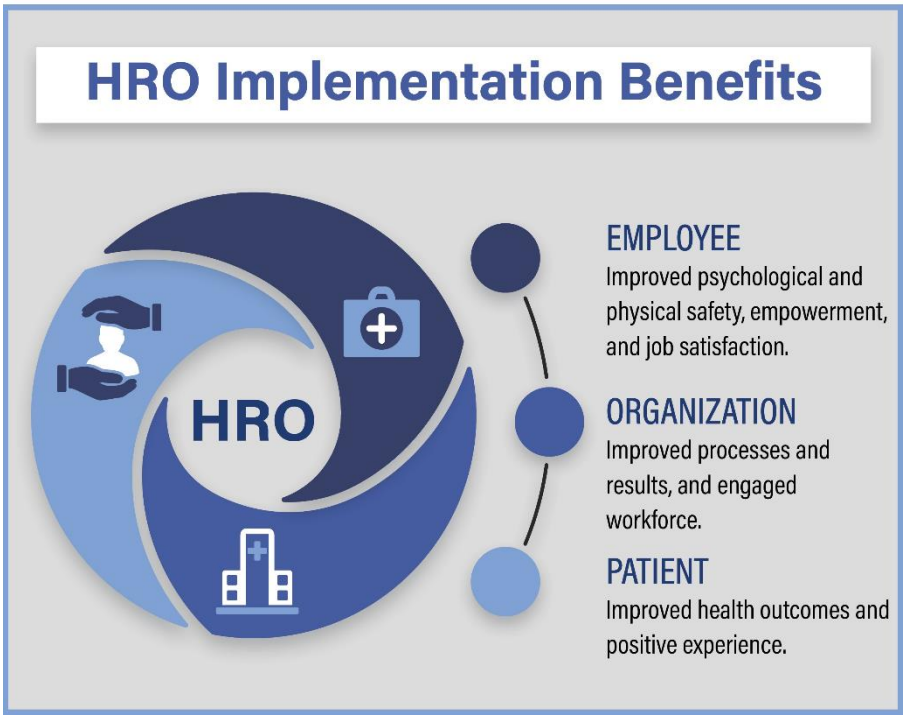



***Figure 2.*** *Potential benefits of HRO implementation.*
*Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

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

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

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

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

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

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

## PACT Act

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

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

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

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

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

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

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

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

# 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 Western New York Healthcare System (facility) consisted of two campuses. The Batavia site opened in 1933, and the Buffalo site opened in 1950. In addition to the two campuses, there are nine outpatient centers.[13] At the time of the inspection, the facility's executive leaders consisted of an Executive Director, Chief of Staff, Associate Director for Patient/Nursing Services, Associate Director, and Assistant Director. The executive leaders had been working together since 2021, except for the Associate Director for Patient/Nursing Services who started in May 2024. In fiscal year (FY) 2023, the facility's medical care budget was $1,907,418,551. The facility provided care to 54,761 unique patients and had 276 operating beds (104 inpatient hospital, 120 community living center, and 52 domiciliary).[14]


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

[13] The facility had nine community-based outpatient clinics located in Buffalo, Dunkirk, Jamestown, Lockport, Niagara Falls, Olean, Packard, Springville, and West Seneca, New York.

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

[15] 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.

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

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

## System Shocks

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

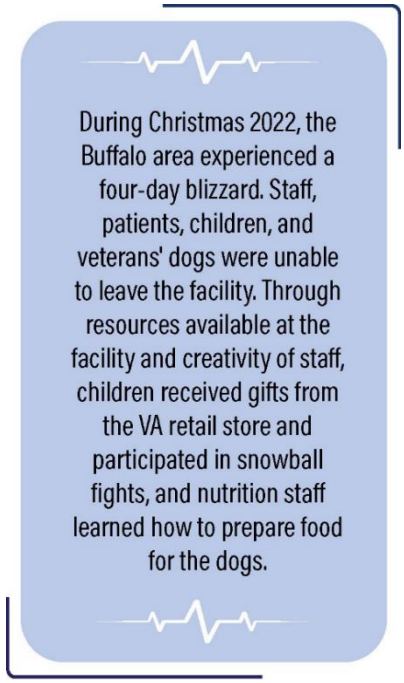



***Figure 4.*** *Facility systems shocks. Source: OIG analysis of an interview.*

In an interview, executive leaders identified inclement weather as being the biggest system shock that recently affected the facility. They described a four-day blizzard in 2022 that produced six feet of snow and took several days for the facility to return to normal operations. Leaders reported staff, patients, children, and some veterans' dogs were stranded at the facility. Leaders added that some patients remained in the hospital longer than planned, and outpatient dialysis patients were admitted to the hospital because they could not be discharged due to the snow.

From this event, leaders stated they learned valuable lessons that they employed during a snowstorm the following year, including having additional staff, medical supplies, food, linens, and other resources like cots for staff to sleep on, available prior to the storm. Staff rescheduled patient appointments or changed them to telehealth appointments to ensure timely care. Leaders also reported working collaboratively with staff at the community-based outpatient clinics to coordinate care and resources. The OIG made no recommendations.

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

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

## Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] 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.[21] 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."[22] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23]

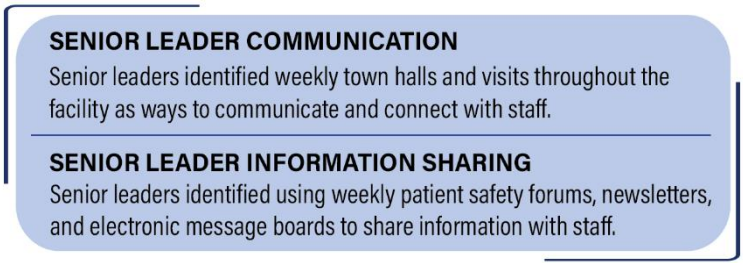



***Figure 5***. *Leader communication with staff.*
*Source: OIG interviews.*

The facility's All Employee Survey scores showed consistent improvement from FY 2021 to FY 2023. In an interview, leaders credited the continuous score improvements to communication with staff, transparency of information, and the use of HRO principles. Leaders reported conducting weekly town hall meetings, patient safety forums, and visits to clinical and nonclinical areas both to provide information and to listen to staff; they also shared information through a weekly newsletter and messaging boards. Responses to the OIG-administered questionnaire showed staff largely agreed that facility leaders changed how they communicated information, the changes were an improvement, and the communication was clear. The OIG made no recommendations.

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

[21] 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*.

[22] 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.

[23] 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.

## Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[24] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[25] 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.[26] 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.[27] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.


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

The OIG reviewed the facility's employment data and found it did not meet the target for veteran employment rates but did meet the target for individuals with disabilities (see figure 6). The OIG also noted All Employee Survey workplace diversity scores improved each year from FYs 2021 to 2023. Based on information provided by the facility, leaders promoted numerous special emphasis events in calendar year 2023.[28] Leaders described encouraging and promoting participation in these events through emails, electronic messaging boards, social media posts,

[24] 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.

[25] 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.

[26] 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*.

[27] 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.

[28] The special emphasis events included sexual orientation and gender identity, veterans, disabled veterans, federal women's employment, and Native American heritage programs, as well as Martin Luther King Jr. Day, and Juneteenth celebrations.

and the Veterans Experience Committee. Leaders also stated that all managers' performance plans included support for these events and cultural change metrics.

Leaders reported recently hiring a Health Equity Program Manager who focuses on outreach and recruitment of underrepresented populations. Additionally, leaders stated another employee is active in the Native American community and engaging with tribal leaders to help with recruitment. When employees reported feeling racial tension, leaders responded by organizing listening sessions to better understand the employees' points of view and provided opportunities for employees to receive Allyship certification, which helps with personal awareness of bias.

The OIG found executive leaders were committed to prioritizing diversity and inclusiveness through collaboration, special emphasis events, and professional growth opportunities. The OIG made no recommendations.

## Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[29] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[30] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

All Employee Survey scores for best places to work, no fear of reprisal, and supervisor trust improved from FYs 2022 to 2023. Leaders attributed the increase to being genuine, believing in the VA mission, and supporting employees. The Chief of Staff described helping employees feel fulfilled as important members of the team. Leaders added that their visits to work areas positively affected the culture and they believed employees felt empowered to make suggestions to improve the culture and report patient safety events, as demonstrated by responses to the OIG-administered questionnaire.

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

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

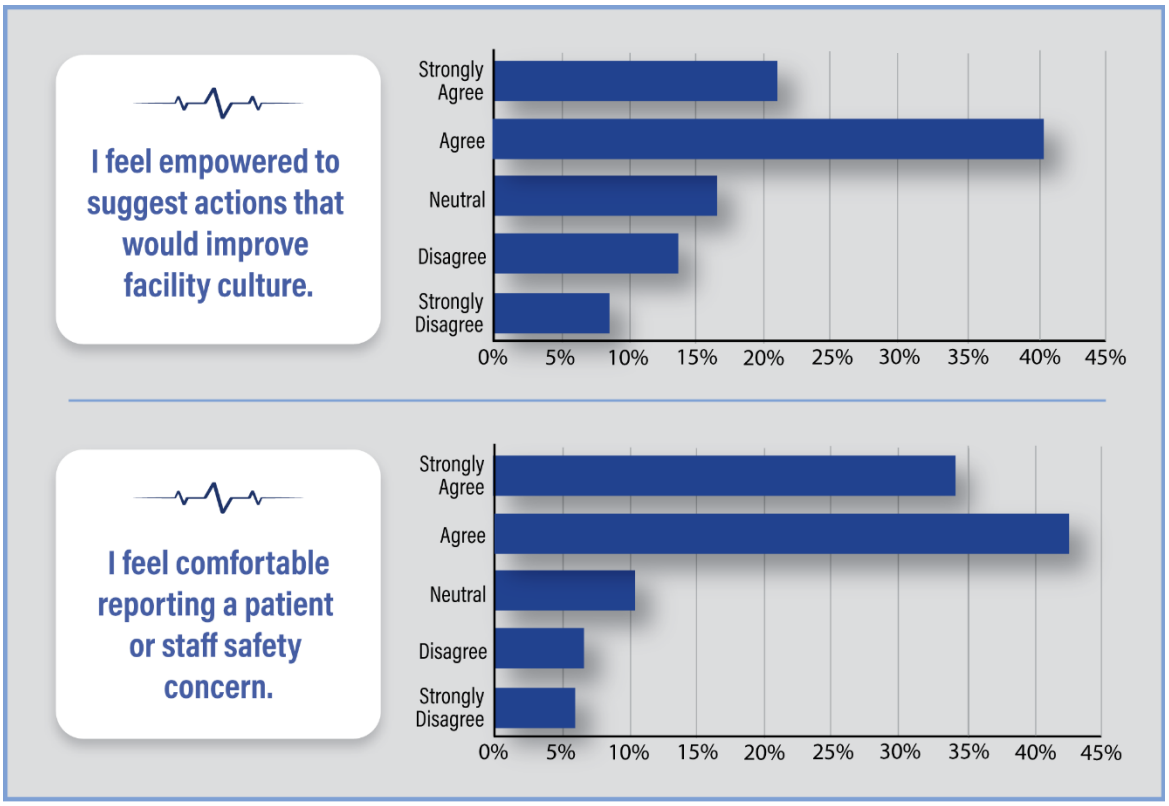



***Figure 7.*** *Employee and leaders' perceptions of facility culture.*
*Source: OIG analysis of questionnaire responses and interviews with facility leaders.*

Leaders highlighted employee burnout and position vacancies as two identified areas of concern. In response, they used various efforts to improve engagement and employee enrichment, including offering nurse manager training, mentorships for new employees, and leadership development programs.

During an interview, the Chief of Staff reported on challenges in recruiting specialty care providers like those for hematology-oncology, neurology, and gastroenterology. The facility reported longer wait times for these specialty services and noted the availability and use of community care services. The OIG team (Team A) was aware that a separate OIG team (Team B) was addressing allegations of delays in community care and concerns with facility leaders' failure to resolve these delays; therefore, Team A did not further explore these issues.[31] In August 2024, the Executive Director and the Chief of Staff were transferred out of their positions pending results of an investigation related to failures in addressing delays in community care.[32]

[31] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

[32] On September 27, 2024, the OIG published a report detailing the results of Team B's inspection: VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, Report No. 23-03679-262.

The OIG also reviewed VA survey questions and leaders' interview responses related to psychological safety. Survey scores for psychological safety improved from FYs 2022 to 2023. Facility leaders informed the OIG that they focused on promoting HRO principles at the facility through education, as well as challenging employees to question processes and facility operations. Leaders also mentioned there was an increase in reported close calls, which they felt demonstrated employees' comfort with disclosing problems. The OIG made no recommendations.

## Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[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.

Based on an interview with leaders and the Patient Advocate's response to an OIG-administered questionnaire, there were no concerns or complaints related to PACT Act implementation. The Patient Advocate reported the three most common complaints were about care in the community billing, staff communication delays, and lack of education from providers. Leaders reported reviewing the patient advocate reports and working with supervisors, managers, and quality management staff to address any concerns.

Leaders stated they met quarterly with the VSOs and the Veterans Experience Group, of which the VSOs are members, to discuss patient complaint issues and trends. Leaders further said they had a good working relationship with the VSOs, but the representatives were not on-site at the facility as often as they used to be. Four VSO questionnaire respondents identified length of time to get appointments, lack of promised call-backs from staff, practitioner availability for specialty care, and lack of parking during busy hours as the most common veteran complaints. Leaders stated another common complaint involved beneficiary travel reimbursement: a previous option to receive immediate cash reimbursement from travel staff was no longer available. The current process requires veterans to use a kiosk to request reimbursement and have funds deposited into their bank account; leaders reported ensuring the updated process was explained to veterans. Overall, the VSO respondents reported feeling they could provide feedback to leaders about veteran issues, and leaders were generally responsive to them and the veterans' concerns. The OIG made no recommendations.

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

***Figure 8.*** *Facility photo.*
*Source: "Buffalo VA Medical Center," Department of Veterans Affairs, accessed May 6, 2024, https://www.va.gov/western-new-york-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.

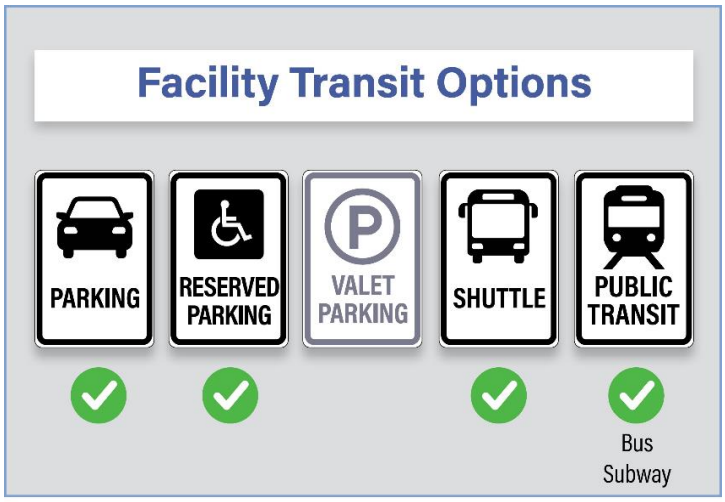



***Figure 9.*** *Transit options for arriving at the facility.*
*Source: OIG analysis of an interview.*

The OIG used the navigation link located on the facility's public website to obtain directions to the parking garage, which faced the main entrance. The OIG found the parking garage to be well lit, with emergency call buttons and security cameras; it included general and accessible parking spots, with some specifically reserved for individuals with spinal cord injuries. According to facility staff, public transit, including buses and subways, were within 1.5 miles of the main campus, the homeless program, and the partial day care program. The public bus stops at the main campus more than three times a day. In addition, public transit offers door-to-door services for disabled patients and staff. The facility also provided staff shuttles Monday through Friday from an off-site parking lot. The OIG made no recommendations.

## Main Entrance


***Figure 10.*** *Facility front 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]

The OIG noted the main entrance to the facility was well marked by signage in the driveway, in the parking garage, and on the main building. The OIG found the main entrance had a patient loading zone with a canopy to shelter patients and visitors and was accessible with several different textured flooring surfaces.

[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*.

The OIG team entered the facility through two sets of power-assisted doors and, once inside, found a generally well-maintained entrance area with ample wheelchairs and VA police present. However, the main entrance was a relatively confined space and appeared dimly lit. The building dated to 1947, and facility leaders explained the original main entrance was restricted to employees for security after the 1995 Oklahoma City bombing, with an alternative entrance established for public use. Past the security checkpoint, the OIG noted a café that served food and drinks with seating available. Because of the limited entrance space, staff used other areas throughout the facility (the café and canteen) to host gatherings with musicians and vendors. The OIG made no recommendations.

## Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[39]

The OIG noted volunteers staffed the facility's information desk and provided printed maps and informational pamphlets to veterans and visitors. The OIG found the color-coded maps to be current, correct, and readily available throughout the facility. In addition, there were wall-mounted signs and digital screens hung by the main elevator lobby to assist veterans in navigating the facility and advertise current events.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[40] The OIG found no accessibility-related complaints made to the patient advocates. During a walk-through

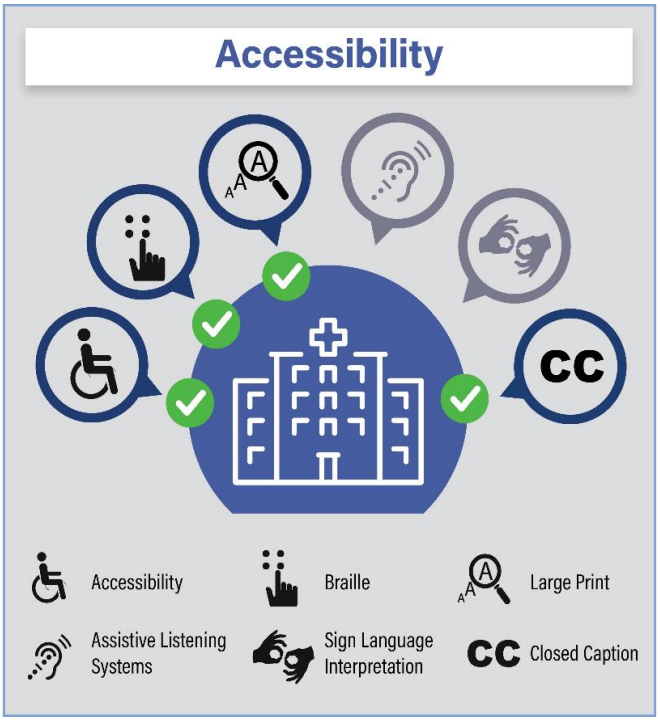



***Figure 11.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: OIG analysis of documents and interviews.*

[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/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

inspection, the OIG confirmed the presence of braille on signage located throughout the facility. A volunteer at the information desk stated they assess any veteran that presents at the information desk and assist as needed to meet their needs. The OIG made no recommendations.

## Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[41]

Facility staff reported having two toxic exposure screening nurse navigators, as well as a dedicated physician and nurse practitioner to examine veterans and enter consults for specialty care and diagnostic codes in the patients' electronic health records as needed. In an interview, a navigator described the facility's screening processes and resources, which included staff screening veterans at scheduled and walk-in appointments or at outreach events. If a veteran indicated exposure to toxins, staff referred them for a secondary screening with either their primary care or toxic exposure screening providers and supplied information on local resources related to toxic exposure.

The OIG found facility staff had conducted approximately 27,000 initial toxic exposure screenings between August 10, 2022, and April 19, 2024. Of the veterans initially screened, approximately 13,000 reported being exposed to toxins. Between March and September 2023, staff reported hosting 11 PACT Act outreach events. A toxic exposure screening provider and navigator stated the program would benefit from a dedicated full-time administrative assistant to help with management, such as calling veterans for follow-up appointments. The OIG made no recommendations.

## Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[42] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

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

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

The OIG found the facility exceeded VHA's performance target for closing identified environment of care deficiencies or creating action plans to address them within 14 business days. VHA set the target at 90 percent, and the facility's overall compliance rate for FY 2023 was 92.3 percent. Leaders also exceeded VHA's 90 percent target for attending environment of care rounds, achieving 100 percent compliance. In an interview, the Comprehensive Environment of Care Committee leaders explained that committee members used VHA's required assessment and compliance program consistently and effectively. The OIG did not identify any repeat findings. The OIG made no recommendations.

## General Inspection

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

The OIG inspected clinical and non-clinical areas and found the facility to be generally clean and safe, with veterans' privacy maintained.[43] The OIG noted there were clear exit paths and patients were able to move freely. In addition, the OIG found all inspected medical equipment had current inspection stickers and no protected patient information was visible. Facility staff complied with requirements for storing expired, damaged, and contaminated medications; identifying biohazard waste; and restricting access to supply rooms. The OIG observed one refrigerator door with dirty shelving; staff immediately cleaned it.

The OIG found the main entrance to the community living center's Willow Lodge unit to be narrow but inviting.[44] The unit had a homelike environment and a newly renovated bereavement room for families. Although kitchen staff delivered meals to the residents, the OIG observed a small kitchenette area for residents and families, which had snacks, juice, and milk readily available. The OIG made no recommendations.


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.

[43] The OIG inspected the following clinical areas: the emergency department, an intensive care unit, a medical-surgical inpatient unit, and an outpatient clinic.

[44] Willow Lodge consisted of a hospice unit and a sub-acute unit.

## 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 determined the facility had processes to communicate abnormal test results to ordering providers, identify a surrogate provider when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours. In an interview, the Chief of Staff acknowledged the current processes needed improvement to ensure automated escalation of urgent, noncritical test results when ordering providers and surrogates were unavailable. In September 2024, the facility provided updated policies related to communication of test results that defined their process for surrogate assignments and coverage.

The Chief of Staff and quality management staff acknowledged the potential for missed opportunities related to communication of abnormal test results when providers did not review view alerts (notifications in electronic health records). They stated the informatics team reviewed reports of unopened view alerts for abnormal results and escalated unopened alerts to service chiefs to address. The Chief of Staff reported not reviewing alert data; however, after primary care providers brought up concerns about burnout due to alert fatigue, the chief described considering a new way to reduce the number of view alerts providers received.[47] The new process involved clustering test results and reporting them together within a defined time frame.

The OIG found facility staff performed quarterly internal audits related to the communication of test results. In an interview, the Chief of Staff and quality management staff reported that the internal audit did not identify any major delays in notification of test results. The OIG made no recommendations.

[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.

[47] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

## Action Plan Implementation and Sustainability


***Figure 12.*** *Status of prior OIG recommendations. Source: OIG report.*

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

Staff reported no open recommendations related to the communication of test results. Staff monitor action plans as needed after implementation to ensure sustained improvements and report progress monthly to executive leaders. The OIG did not identify any barriers to long-term improvements related to general patient safety. The OIG made no recommendations.

## Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[49] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[50] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Based on a review of facility-provided documentation, the facility does not currently have any process improvement projects related to communication of test results. The Chief of Staff and quality management staff explained that executive leaders supported improvement projects and there were no barriers to initiating such projects. The Chief of Staff and quality management staff informed the OIG that information from the facility's patient safety reporting system helped staff identify system vulnerabilities, and that quality management staff shared lessons learned and educated staff about process improvements. The OIG made no recommendations.

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

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

[50] VHA Directive 1050.01(1).


The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[51] 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.[52] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[53] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, the facility had no primary care provider or nurse staffing shortages. Although the primary care leaders reported a shortage of administrative assistants, the OIG found patients did not experience increased appointment wait times or delays in care. To prepare for the anticipated increased patient enrollment due to the PACT Act, facility leaders created one new primary care team and hired staff.

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

The OIG found panel sizes had not been a concern for leaders and primary care teams because the panels were not full. In an interview, facility leaders attributed smaller panel sizes to a decrease in patient enrollments due, in part, to slow population growth, and patients relocating to

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

[52] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

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

[54] "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).

[55] VHA Directive 1406(1).

warmer climates or not returning for care following the pandemic. Leaders stated they plan to reassign patients when providers leave the facility and reallocate staff to improve panel fullness.

The facility coordinator for the Patient-Centered Management Module reported assigning patients to teams based on care assessment needs scores, along with input from service chiefs and providers. The primary care team members stated they routinely assess patients' care needs and divert those with high scores to the care coordination and integrated case management team. This specialized team provides individualized care and intensive case management until the patient meets their individualized goals. Once goals are met, patients return to their primary care teams for continued care. A primary care provider mentioned having an equally distributed panel of patients with varying acuity and no concerns related to current panel size. The OIG made no recommendations.

## Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[56] 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.

In interviews, primary care team members stated that facility leaders supported them and worked to resolve issues to improve efficiency and team functioning. Facility leaders added they empowered staff to approach their supervisors with their concerns and collaboratively develop solutions or elevate concerns when appropriate.

Both leaders and team members identified view alerts as a barrier to work efficiency and provided an example of a process improvement project being piloted to help address the issue. For example, primary care nurses identified that they did not address view alerts from patient calls during clinic hours timely, which could delay care. As a result, the nurses implemented a process to divert view alerts and calls to a telephone triage system, where patients could immediately access someone for urgent concerns or leave a message for non-urgent concerns, and their primary care nurse would follow up. Primary care nurses reported this process change significantly decreased workload and improved workflow within their teams. The OIG made no recommendations.

## The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found veteran enrollment rates decreased over the past three years following the PACT Act implementation,

[56] VHA Handbook 1101.10(2).

although facility leaders reported initially increasing staff to meet the projected demand. To increase veteran enrollments, leaders and staff engaged in PACT Act outreach through live events and social media. Primary care team members reported that adding toxic exposure screenings did not affect how the teams functioned or the timeliness of care, and leaders stated PACT Act implementation did not affect patient appointment wait times. The OIG made no recommendations.


The OIG reviewed 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.[57]

### 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).[58] 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."[59]

From FYs 2021 through 2023, VHA exempted the facility's HCHV program from the performance measure because the total number of unsheltered veterans in the service area was too small. Despite the exemption, HCHV staff reported conducting outreach, tracking referrals and outcomes, and discussing engagement attempts during weekly team meetings.

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

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

[59] 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.

In an interview, staff reported the point-in-time count, conducted in January, accurately captured the number of sheltered homeless individuals but due to the harsh winter weather, it was probably less accurate in counting unsheltered homeless individuals. In addition to the point-in-time count, HCHV staff reported collaborating with community partners to create and maintain a list of all homeless veterans in the facility's service area.

HCHV leaders shared that program staff collaborated with facility staff working in mental health, suicide prevention, and primary care clinics, who frequently asked them to find veterans in need of follow-up health care. As a result, program staff developed a mobile outreach team who provided non-emergency interventions to increase engagement with veterans otherwise lost to care. In an interview, program leaders shared an example of a veteran who missed several scheduled dialysis appointments. The mobile outreach team went to the veteran's home, transported the veteran to dialysis, and arranged ongoing transportation through a community partner for future appointments.

After identification through the point-in-time count, HCHV staff persistently conducted outreach to a wooded area to engage with a homeless veteran who lived in a dilapidated animal enclosure. The veteran had reportedly been living in the enclosure since returning from Vietnam. While the veteran initially declined resources, program staff gained trust by communicating with handwritten notes; providing hygiene products, food, and clothing; and introducing the Chief of Primary Care, who would eventually conduct an initial medical assessment. In time, the veteran was approved for benefits, accepted a referral to Housing and Urban Development–Veterans Affairs Supportive Housing, received a housing voucher and case management services, and rented an apartment. The veteran currently resides in a nursing home due to medical needs.

***Figure 13.*** *Homeless veteran engagement.*
*Source: OIG interview.*

## 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).[60]

The OIG noted the facility program met performance measure targets for HCHV1 and HCHV2 for FY 2023, which leaders partly attributed to the inviting environment of a contracted 16-bed residential home. Additionally, HCHV leaders provided documentation showing that during calendar year 2023, program staff engaged with 121 unsheltered veterans and helped 162 veterans move into permanent housing.

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

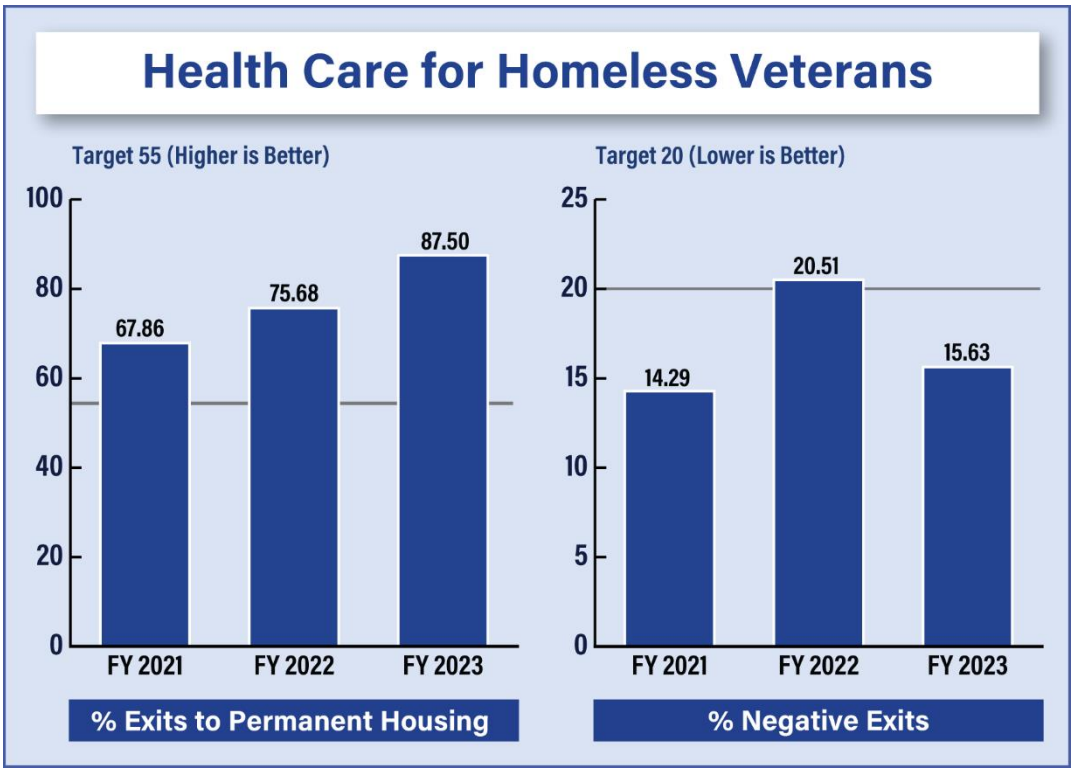



***Figure 14.*** *HCHV program performance measures.*
*Source: VHA Homeless Performance Measures data.*

Further, HCHV staff described surveying veterans to assess their experiences with the facility's homeless programs and solicit their feedback to identify opportunities to improve services. The OIG made no recommendations.

## Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[61] 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.[62]

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

## Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each fiscal year (performance measure VJP1).[63] The facility met the performance measure target for FY 2023. The OIG noted the program team consisted of two Veterans Justice Program specialists and one peer support specialist. The team served six veterans treatment courts and 15 jails and prisons within the facility's seven-county service area.[64] The specialists conducted over 60 outreach and educational events from FY 2021 through FY 2023.


***Figure 15.*** *Veterans treatment court.*
*Source: OIG analysis of documents.*

In an interview, program staff reported receiving referrals from facility mental health providers, attorneys, and court coordinators. After receiving referrals, the program specialists engage with the veterans, assess their psychosocial needs, refer them for medical and mental health services as necessary, and provide case management when appropriate.

## Meeting Veteran Needs

In documentation provided by the Community Day Programs Manager, the OIG found that the program's strategic plan includes an increase in services for black veterans, who despite similar arrest rates, have higher incarceration rates within the facility's service area. Therefore, the program specialists stated that an identified goal was to increase outreach to minority veteran populations within the prison systems. Program staff track the targeted outreach and education efforts and entered the information into a national database.

The program specialists stated they serve as instructors for local law enforcement training, presenting on topics such as VA resources and crisis intervention skills. The specialists attend community-based meetings, participate in weekly community day programs and team meetings, and present on justice program services during Mental Health Awareness Month activities at the facility. Program staff further reported a collaborative agreement with a community partner to provide free legal services to veterans involving public benefits, housing, family law, and basic estate planning.

[63] 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*.

[64] Veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially-supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06(1), *Veterans Justice Programs (VJP)*, September 27, 2017, amended March 3, 2020.

Program staff also highlighted their commitment to *deflection*, a prevention model that connects health systems and law enforcement, creating a bridge for high-risk veterans to engage in treatment before potential involvement in the criminal justice system.[65] They described their goal of coordinating with VA police and local law enforcement to form a deflection implementation team. The OIG made no recommendations.

## Housing and Urban Development–Veterans Affairs Supportive Housing

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

### Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[68] The OIG found the facility's program met the performance measure target for FYs 2021 and 2023 but not for FY 2022.

In an interview, program leaders described difficulties engaging with veterans living in remote and rural areas; some are transient, and few shelters are available to conduct outreach. Program staff reported expanding outreach activities and strengthening relationships with community partners by assigning points of contact to help connect more veterans to homeless resources.

On September 1, 2016, the United States Interagency Council on Homelessness recognized the facility's homeless program, their community partners, and local leaders in ending homelessness in the cities of Buffalo, Niagara Falls, Tonawanda, and Lockport and in the counties of Erie, Niagara, Orleans, Genesee, and Wyoming.

***Figure 16.*** *Program highlight. Source: OIG review of a document.*

[65] Deflection is a "preventative approach" connecting public safety and public health systems "that offers pathways for a community-based treatment response to occur before an event such as an overdose, arrest, or mental health crisis." "Police, Treatment, and Community Collaborative," Police, Treatment, and Community Collaborative, accessed June 4, 2024, https://ptaccollaborative.org/PTACC.pdf.

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

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

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

In an interview, program leaders described focusing outreach efforts on identifying and enrolling veterans who need housing and case management services. The goal is to quickly assist veterans in securing permanent housing, but delays can occur when veterans do not have all the documents required by the public housing authority. For example, program staff reported that homeless individuals often do not have proof of legal name changes, birth certificates, and marriage or divorce paperwork, which the housing authority requires to issue vouchers. Program staff assist veterans in obtaining necessary documents.

The program supervisor said staff also encouraged veterans to apply for VA and Social Security benefits when appropriate. Program staff work with a Veterans Benefits Administration representative who efficiently processes applications, and two staff have received specialized training to assist veterans with applying for Social Security assistance.

## Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[69] The OIG found the facility's Housing and Urban Development–Veterans Affairs Supportive Housing program met the performance measure target for FYs 2022 and 2023. In an interview, program leaders emphasized the work of the Employment Coordinator as essential to achieving the target. The coordinator maintained regular contact with case managers; ensured the program's database accurately reflected veterans' employment status; attended job fairs; and identified veteran-friendly employers, one of which has hired and promoted disabled veterans.

A Vietnam-era veteran discreetly lived in a home without electricity, heat, and running water for more than twenty years. In 2021, the city of Buffalo deemed the house uninhabitable and ordered it to be torn down. The veteran sought assistance from HCHV program staff who offered resources including meals and hot showers. Additionally, the veteran was referred to Housing and Urban Development–Veterans Affairs Supportive Housing and received a voucher, which they used to secure stable housing in an assisted living facility.

***Figure 17.*** *Program success story. Source: OIG analysis of documents and interviews.*

Leaders jointly recognized program staff and community partners for developing services for any veteran experiencing homelessness to quickly receive needed support and resources to secure a permanent home. The program coordinator reported working with partners who assisted veterans to obtain security deposits, household items and beds, food, legal services, tenant education, and recreational experiences. The OIG made no recommendations.

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

# Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and did not provide any recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

# 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 thirteen VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 22 through April 25, 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.

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

[2] The OIG received responses from five VSOs (Marine Corps Veterans and Veteran Advocate, Vietnam Veterans of America Chapter 77, Veteran and Advocate for OIF-OEF era Vets, Erie County American Legion Commander, and Western New York American Red Cross) based on VA's statement that "VA works most closely with [these organizations]." VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/opa//veo/traditionalVeteranOrganizations.pdf.

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

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

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.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

# Appendix B: Facility in Context Data Definitions

### Table B.1. 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.*

## Table B.2. Health of the Veteran Population*

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

| Category | Metric | Metric Definition |
|---|---|---|
| **Staff Retention** | Onboard Employees Stay < 1 Year | VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee. |
| | Facility Total Loss Rate | Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely. |
| | Facility Quit Rate | Voluntary resignations and losses to another federal agency. |
| | Facility Retire Rate | All retirements. |
| | Facility Termination Rate | Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments. |

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

# Appendix C: Additional Facility Photos

***Figure C.1***. *Veterans Park Memorial.*
*Source: Photo taken by OIG Inspector.*

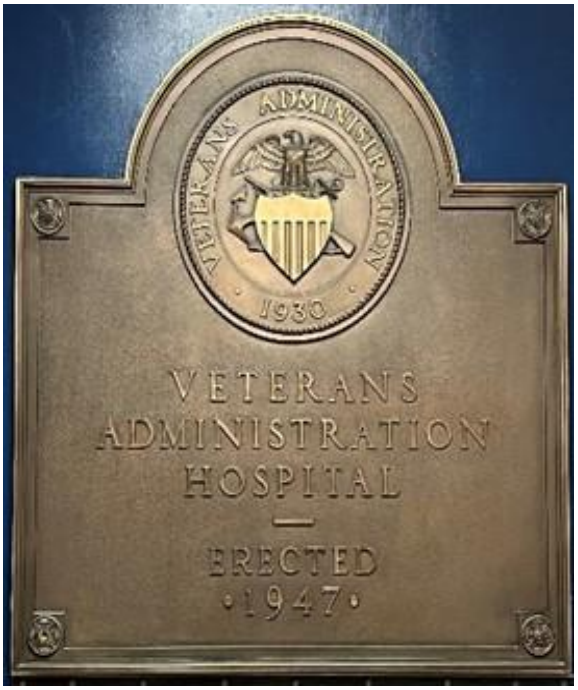



***Figure C.2***. *Facility plaque.*
*Source: Photo taken by OIG Inspector.*

# Appendix D: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: November 19, 2024

From: Director, New York/New Jersey VA Health Care Network (10N02)

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

To: Director, Office of Healthcare Inspections (54HF02)

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

I have reviewed the response to the OIG HFI draft report for the VA Western New York Healthcare System in Buffalo.

I concur with your assessment of the findings and appreciate that there were no recommendations for the VA Western New York Healthcare System. VA Western NY and the entire VISN 2 Network remains committed to continuous improvement.

*(Original signed by:)*

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

# Appendix E: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: November 15, 2024

From: Acting Director, VA Western New York Healthcare System (528)

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

To: Director, New York/New Jersey Health Care Network (10N02)

1. I have reviewed the OIG Healthcare Facility Inspection draft report for the VA Western New York Healthcare System.
2. While the OIG made no recommendations for improvement, VA Western New York Healthcare System remains committed to continuously improving the quality and safety of Veteran care.

*(Original signed by:)*

Shawn De Fries
MS, MBA, RHIA, FACHE – Acting Medical Center Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the Office of Inspector General at (202) 461-4720. |
| **Inspection Team** | Joanne Wasko, MSW, LCSW, Director<br>Jennifer Frisch, MSN, RN<br>Laura Harrington, DBA, MSN<br>Miquita Hill-McCree, MSN, RN<br>Tenesha Johnson-Bradshaw, MS, FNP-C<br>Sheeba Keneth, MSN/CNL, RN<br>Chastity Osborn, DNP, RN<br>Georgene Rea, MSW, LCSW |
| **Other Contributors** | Kevin Arnhold, FACHE<br>Bruce Barnes<br>Myra Brazell, MSW, LCSW<br>Richard Casterline<br>Kaitlyn Delgadillo, BSPH<br>Rose Griggs, MSW, LCSW<br>LaFonda Henry, MSN, RN<br>Cynthia Hickel, MSN, CRNA<br>Brandon LeFlore-Nemeth, MBA<br>Amy McCarthy, JD<br>Scott McGrath, BS<br>Barbara Miller, BSN, RN<br>Sachin Patel, MBA, MHA<br>Ronald Penny, BS<br>Joan Redding, MA<br>Larry Ross Jr., MS<br>Dave Vibe, MBA<br>Dawn M. Woltemath, MSN, RN |

# Report Distribution

## VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 2: New York/New Jersey VA Health Care Network
Director, VA Western New York Healthcare System (528)

## Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Kristen Gillibrand, Charles Schumer
US House of Representatives: Timothy Kennedy, Nicholas Langworthy, Joseph Morelle, Claudia Tenney

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