US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Fargo VA Health Care System in North Dakota

Healthcare Facility Inspection	24-00602-33	January 14, 2025

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

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Executive Summary

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

What the OIG Found

The OIG physically inspected the Fargo VA Health Care System from May 20 through May 23, 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 could not identify any system shocks that had affected the facility's organizational culture over the past few years. The leaders did, however, identify the winter weather as a challenge for recruiting and retaining staff and used incentives like special salary rates and telework positions to address it. Additionally, they relied on staff from the clinical resource hub to provide patient care.[2]

The leaders noted a decrease in the facility's All Employee Survey scores related to leaders' communication for fiscal year 2022 and attributed the decrease to effects of the COVID-19

[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] Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for veterans when local facilities have gaps in care or service capabilities. "Clinical Resource Hubs," VHA Office of Primary Care Clinical Resource Hubs, accessed June 13, 2024, https://dvagov.sharepoint.com/sites/VHAOPCCRH. (This site is not publicly accessible.)

pandemic.[3] To improve communication with staff, the leaders reported embracing the high reliability organization model by sharing information during daily huddles, town halls, visits to work areas, and patient safety forums. They also strived to create a workplace for staff's professional development and psychological safety.[4] Based on responses to the OIG-administered questionnaire, most staff felt comfortable suggesting actions to improve facility culture and reporting a patient or staff safety concern. Further, the OIG found that leaders prioritized inclusiveness through diversity-focused events and responded to veterans' concerns brought forward by the Patient Advocate and veterans service organization representatives.

Environment of Care

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

The facility's parking lot had available spaces, a shuttle service to transport veterans from the parking lot to the main entrance, and security systems to maintain safety. The main entrance was well-lit and included a foyer that was heated during the winter, providing a warm, enclosed space for veterans to wait for their rides. Once inside, the OIG observed walls decorated with greeting cards from local schools honoring veterans and found greeters and escorts ready to assist veterans. The facility had wall and handheld maps that were clear and easy to read and enlarged directions and braille on various signs.

As of April 2024, staff had completed initial toxic exposure screenings for 73 percent of the facility's enrolled veterans. Staff educated veterans about toxic exposure and the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act through outreach events, social media, and press releases.[5]

The OIG did not identify any persistent environment of care deficiencies. However, the OIG observed an unlocked soiled utility room that did not have a biohazard sign on the door; staff

[3] 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.

[4] 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*.

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

corrected the issue during the site visit. Overall, the OIG found the facility to be clean and well maintained.

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 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.

To minimize delays in providers responding to alerts in electronic health records and communicating test results to patients, clinical application coordinators review test result alert data and notify providers' supervisors of any delays. If delays occur, the Chief of Staff meets with the identified providers about alert management and educates them on how to respond to alerts more efficiently. Fiscal year 2023 internal audit results showed the facility was at 91.7 percent compliance for the communication of test results.

Although the facility had no open or closed recommendations related to the communication of test results, quality management staff stated the Readiness Coordinator maintained a database of all recommendations and action plans and tracked them to completion. The Chief of Quality Management and quality management staff review open recommendations and action plans; once a recommendation is closed, they continue to monitor the changes for a year to ensure sustained improvements.

Staff mentioned recently holding an Innovation and Excellence Expo with booths to spotlight innovation and opportunities for improvement across the facility. One booth showcased training for high reliability organization principles using an escape room, and the facility's patient safety managers presented this project at the annual VHA National Patient Safety.[6]

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.

[6] An escape room is "a game in which participants confined to a room or other enclosed setting (such as a prison cell) are given a set amount of time to find a way to escape (as by discovering hidden clues and solving a series of riddles or puzzles)." *Merriam-Webster,* "Escape Room," accessed October 18, 2024, https://www.merriam-webster.com/dictionary/escape/room.

Although facility staff reported a shortage of primary care providers, registered nurses, licensed practical nurses, and administrative assistants, patients did not experience increased appointment wait times or delays in care. Leaders described developing a provider gap coverage pool to cover staffing shortages or absences. Staff reported this gap coverage pool was reasonable and that teams worked together.

To prepare for an anticipated increase in veteran enrollment due to the PACT Act, facility leaders reviewed provider-to-patient ratios and hired additional staff. However, enrollment decreased, which leaders attributed to a general population decline in the service area and more veterans using care in the community options.[7] To increase enrollments, facility leaders and staff engaged in PACT Act outreach and social media promotions.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs.

The OIG found the facility had active homeless programs, and program staff developed a tracking system to monitor all the programs' activities. All homeless program staff worked closely with community partners to identify homeless veterans and provide them services and resources. The homeless programs cover North Dakota and parts of Minnesota and South Dakota; staff recently reported that the areas in Minnesota covered by two community-based outpatient clinics reached functional zero for the first time.[8] Despite challenges meeting all their performance targets, the OIG found the facility's homeless programs worked to meet the targets' intent through their interactions with the veterans and community resources.

[7] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed August 9 2024, https://www.va.gov/communitycare/.

[8] Functional zero means a "community never has more veterans experiencing homelessness than it has demonstrated it can house in an average month." "Ending Veteran Homelessness in Virginia: A Statewide Collaboration," National Alliance to End Homelessness, November 8, 2018, accessed June 13, 2024, https://endhomelessness.org/resource/ending-veteran-homelessness-virginia-statewide-collaboration/.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes C and D 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

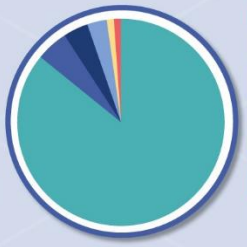
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

Fargo VA Health Care System
Fargo, North Dakota
Level 2-Medium Complexity
Cass County
Hospital Referral Region: Fargo, ND/Moorhead, MN

Description of Community

RACE AND ETHNICITY



MEDIAN INCOME

$58,138

EDUCATION

93% Completed High School
70% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **122**

POPULATION

Female **431,134**
Male **440,814**
Veteran Female **5,234**
Veteran Male **51,048**

Homeless - State **610**
Homeless Veteran -State **37**

UNEMPLOYMENT RATE

3% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

SUBSTANCE USE

38.2% Driving Deaths Involving Alcohol
23.8% Excessive Drinking
121 Drug Overdose Deaths

TRANSPORTATION

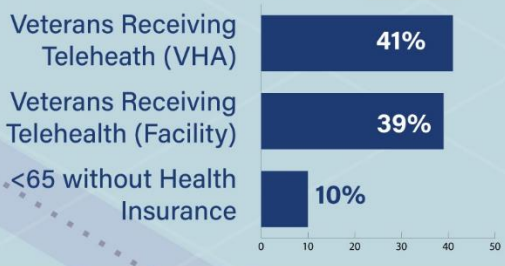
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**52 Minutes, 52 Miles**
Specialty Care	**112 Minutes, 105 Miles**
Tertiary Care	**288 Minutes, 308 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **12,351**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

6,651

115 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.99 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

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

Health of the Facility

UNIQUE PATIENTS

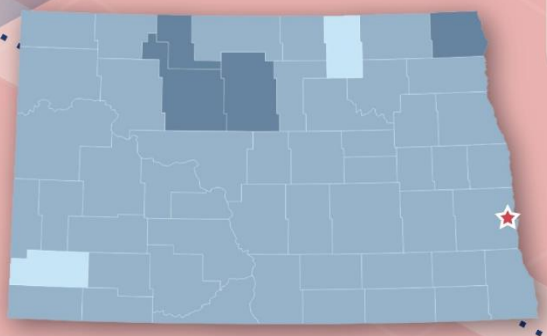
Unique Patients VA and Non-VA Care	36K
Unique Patients VA Care	33K
Unique Patients Non-VA Care	22K

COMMUNITY CARE COSTS

Unique Patient $49,169	Outpatient Visit $279
Line Item $5,133	Bed Day of Care $391

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.99%
Facility Total Loss Rate	10.37%
Facility Retire Rate	1.91%
Facility Quit Rate	7.39%
Facility Termination Rate	0.84%



★ VA MEDICAL CENTER

VETERAN POPULATION (%)

0-5 5-10 10-15 15-20 >20

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

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

VHA facilities; inform veterans, the 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]

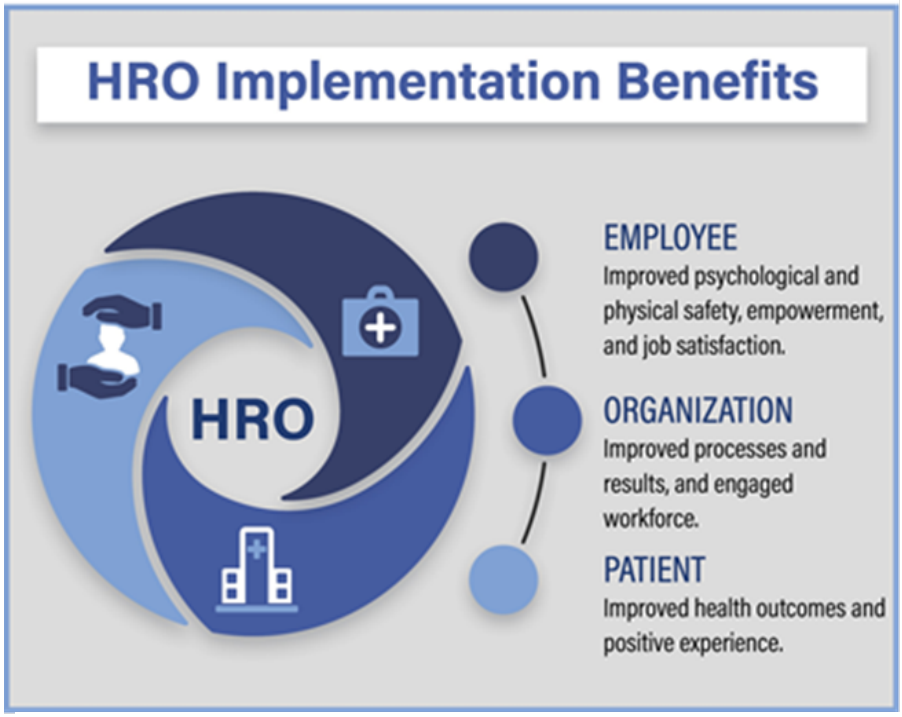


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 May 23, 2023, 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. (This web page is not publicly accessible.)

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

PACT Act

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

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

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

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

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

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

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

Content Domains

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

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

The Fargo VA Health Care System (facility) opened in June 1929 and currently provides care at the main campus in Fargo, North Dakota, and through 10 outpatient clinics.[13] At the time of the inspection, the facility's executive leaders consisted of a Director, Associate Director, Chief of Staff, and an Associate Director for Patient Care. The executive leadership team had been working together since February 2024, when the Chief of Staff was hired. In fiscal year (FY) 2023, the facility's medical care budget was $485,353,850. The facility provided care to 35,223 unique patients and had 75 operating beds (37 inpatient hospital and 38 community living center).[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 has six community-based outpatient clinics located in Grand Forks, Bismarck, Jamestown, and Minot, North Dakota; and Fergus Falls and Bemidji, Minnesota; and four outpatient services located in Devils Lake, Williston, Dickinson, and Grafton, North Dakota.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024.

[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.

In an interview, the facility's executive leaders could not identify any system shocks over the past few years that affected the organizational culture. Leaders stated their locations and weather made recruiting and retaining staff challenging, explaining the healthcare system included the medical center in North Dakota and community-based outpatient clinics that cover areas of North Dakota, Minnesota, and South Dakota, where winter snowstorms involved blizzard-like conditions. Leaders discussed staffing challenges with operational and clinical positions. For example, they had difficulty hiring medical support assistants for the care in the community program.[20] In response, leaders reported using incentives like special salary rates and telework to increase recruitment and retention, and staff from the clinical resource hub to provide care.[21] The leaders also made the care in the community medical support assistant positions remote, which reportedly increased the number of applicants and improved retention.

[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*.

[20] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, http://www.va.gov/communitycare/.

[21] Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for veterans when local facilities have gaps in care or service capabilities. "Clinical Resource Hubs," VHA Office of Primary Care Clinical Resource Hubs, accessed June 13, 2024, https://dvagov.sharepoint.com/sites/VHAOPCCRH. (This website is not publicly accessible.)

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[22] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[23] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[24] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[25]

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

During an interview, leaders acknowledged survey scores decreased in FY 2022, and attributed the decrease to effects of the COVID-19 pandemic; leaders held meetings either virtually or in-person with staff wearing masks, both creating communication barriers. Survey scores improved in FY 2023.[26] Leaders attributed the improved scores to meeting in person and without masks and walking through the facility to observe clinic practices and operations and speak with staff. Leaders also reported conducting virtual walk throughs for those working remotely, town hall meetings, and patient safety forums to share information with staff. The Associate Director for Operations stated that service leaders visited different areas in pairs each month, with the goal of each leader visiting the other services throughout the year.

Additionally, leaders reported embracing the HRO model and teams using daily huddles to share information and solve problems. In the huddles, teams used visual boards to communicate

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

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

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

[25] 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.

[26] The facility's All Employee Survey scores increased from FY 2022 to FY 2023; scores for communication increased from 3.83 to 3.92, information sharing from 3.65 to 3.72, and transparency from 3.81 to 3.93.

information and coordinate their work. The huddles also allowed staff to resolve problems at the team level or escalate them to leaders as needed.

The OIG-administered questionnaire largely showed staff agreed or strongly agreed that leaders made changes to how they communicated, and the changes were an improvement. Staff also indicated that leaders communicated clearly, and the information was useful.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[27] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[28] 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.[29] 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.[30] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.

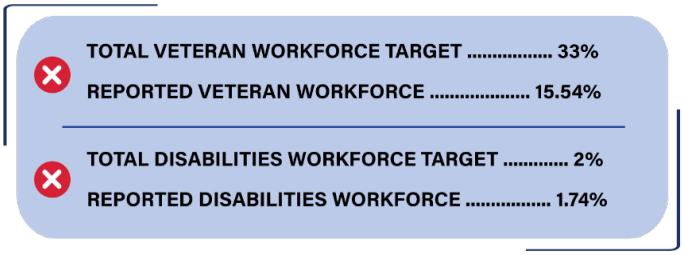


Figure 5. *Facility workforce diversity.*
Source: OIG analysis of facility human resources data.

The OIG noted All Employee Survey scores for workplace diversity declined in FY 2022 but improved in FY 2023.[31] To demonstrate efforts to promote workplace diversity and

[27] 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.

[28] 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.

[29] 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*.

[30] 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/InfoBrief_IncreasingVAWorkforceDiversity_June2023_FINAL.pdf.

[31] The facility's All Employee Survey scores for workplace diversity were 4.29 for FY 2021, 4.14 for FY 2022, and 4.21 for FY 2023.

inclusiveness, the facility provided documentation of various events that occurred in calendar year 2023.[32] Leaders stated they encouraged participation in these events through the facility's newsletter, lunch-and-learns, social media posts, and the Public Affairs Office; they also recorded some events for staff to view at their convenience.

Further, leaders discussed focused outreach to Native Americans and participation in community events. The leaders also stated they decided to fly the Pride flag in June 2023 and received both positive and negative feedback from staff and veterans over this decision. The leaders conceded to one concern by not flying the Pride flag next to the American flag; otherwise, they responded to the feedback by stating they serve all veterans.

[32] The events included Women's History Month; Black History Month; and events celebrating Asian-American/Pacific Islanders, Indian, Peruvian, and Hispanic heritage; a Pride celebration; and a women's health retreat.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[33] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[34] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

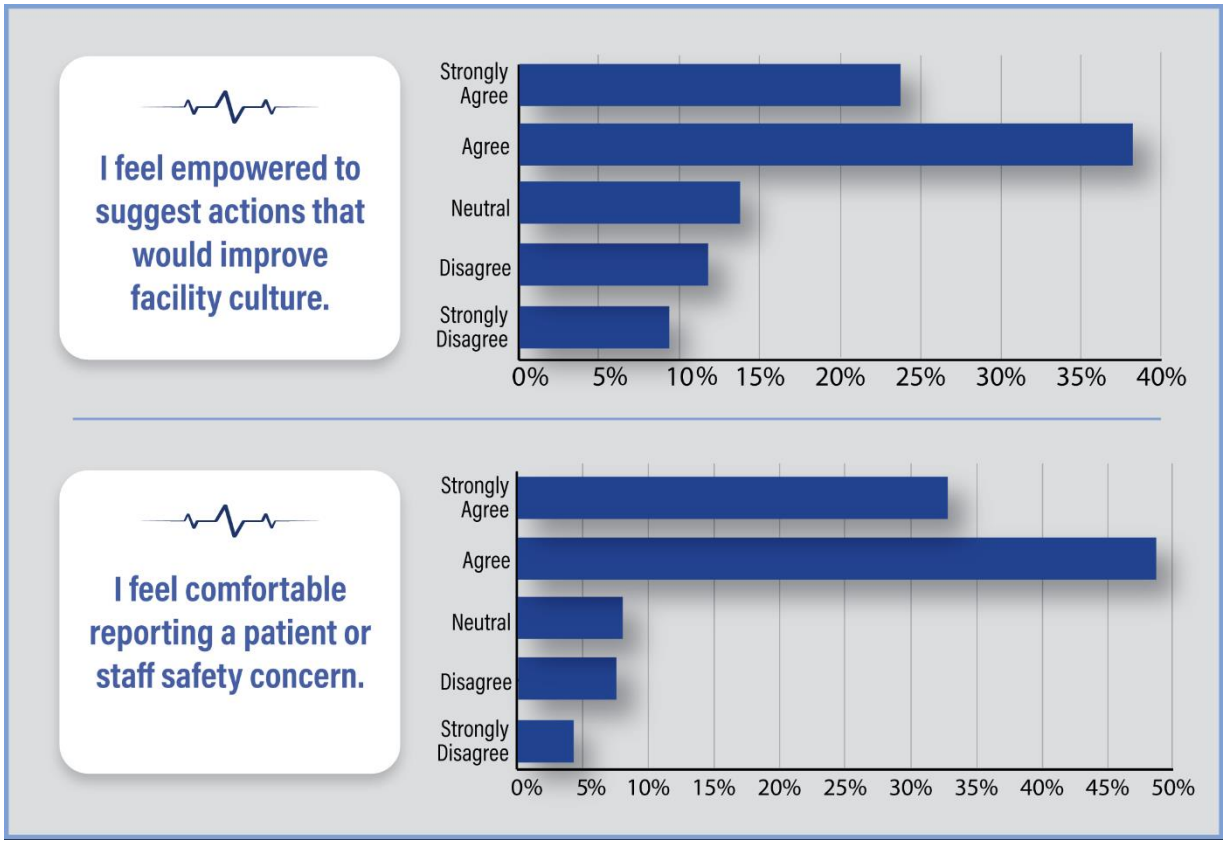


Figure 6. *Employees' perceptions of facility culture and psychological safety.*
Source: OIG analysis of questionnaire responses.

The OIG found that All Employee Survey scores for best places to work, no fear of reprisal, and supervisor trust improved from FYs 2022 to 2023 and were higher overall compared to VHA scores nationally. Leaders attributed the increased scores to creating opportunities for

[33] 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.

[34] 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.

employees' professional growth and ability to voice their concerns, as well as to work flexible schedules. Leaders stated that after receiving the survey results each year, they share scores with employees. Then, employee committees identify priorities to address specific scores and develop measurable, action-oriented, realistic, and timed goals specific to each unit, which help leaders establish facility-wide goals.

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.[35] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[36] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In an interview, leaders stated they meet every two months with VSO representatives and the Patient Advocate to discuss issues and trends related to veterans' complaints. The leaders reported having a good working relationship with the VSOs, and that the organizations were willing to disseminate information to veterans on behalf of the facility as needed. Representatives from three VSOs responded to an OIG questionnaire asking for feedback about working with the facility leaders.[37] Overall, VSO representatives reported feeling they could provide feedback to leaders about care provided to veterans, and leaders were responsive to them and veterans' concerns.

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

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

[37] For a list of VSO respondents, see appendix A.

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

Figure 7. *Facility photo.*
Source: "VA Fargo Health Care," Department of Veterans Affairs, accessed October 15, 2024, https://www.va.gov/fargo-health-care/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[39] 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.[40]

[38] VHA Directive 1608(1).

[39] 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.

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

Transit and Parking

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

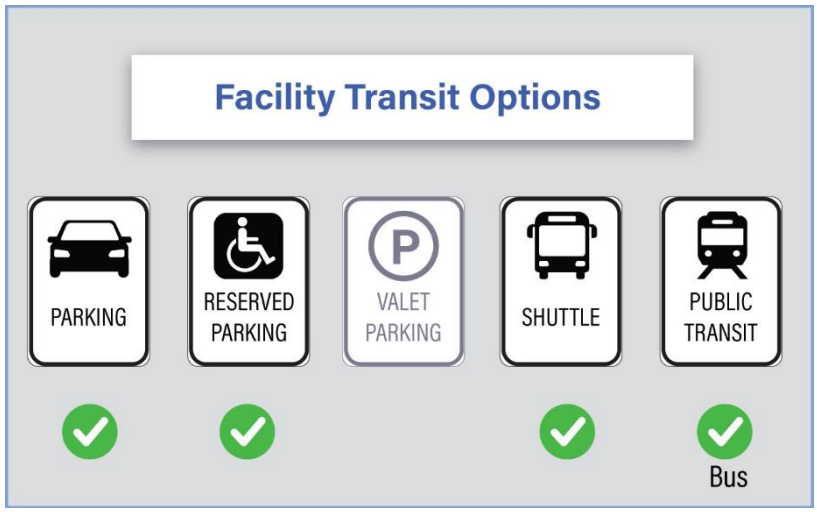


Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

The OIG used the navigation link located on the facility's public website to obtain directions to the parking lot, which faces the main entrance. The OIG found the parking lot to be well-lit, with standard spaces and those accessible for individuals with disabilities. The parking lot's security measures included mounted cameras providing video coverage, police patrols, and emergency call boxes in each row. The OIG observed the facility's shuttle van circling the parking lot, picking up and dropping off veterans going to and from the main entrance. A VSO provided free van rides to the facility for those veterans without other transportation options. A public transit bus also services the facility's main campus in Fargo.

Main Entrance

Figure 9. *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.[41]

The OIG found the main entrance had clear markings and signs identifying it, and a canopy that offered protection from inclement weather. The entryway was on one level, and an automatic power door led into a well-lit foyer that offered veterans a warm place to wait for rides during cold weather and reduced outside debris tracked into the facility. After entering the facility through the foyer, the OIG found the

[41] 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*.

entrance area had large windows and skylights, and walls decorated with greeting cards from local schools honoring veterans.

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.[42]

The OIG observed that during normal working hours, facility staff and a police officer were present at the information desk, as well as greeters and escorts to assist veterans. The OIG also observed an ample supply of wheelchairs at the entrance and information desk. The OIG noted a map prominently displayed on the wall near the main entrance, handheld maps available at the information desk, and maps posted at the elevators and along corridor walls. The maps were clear, legible, and easy to read, and had building wings identified with letters and corridors identified with numbers to assist veterans in finding their way.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[43] For those veterans with visual impairments, the OIG noted the use of braille and enlarged directions on signs throughout the facility. Elevators had braille signs and an audible tone announcing each floor. The Chief of Optometry informed the OIG that for veterans with visual impairments, the facility's low vision clinic providers evaluated them and supplied them with assistive equipment or taught them how to use a cane for better navigation

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

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

[43] 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.

throughout the facility, in their homes, and in the community. In addition, for veterans with hearing impairments, facility leaders contracted with an American Sign Language interpreter service to assist 24 hours a day, seven days a week.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators.[44] The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[45]

Through an OIG-administered questionnaire, the OIG found providers screened veterans for toxic exposure during scheduled appointments or as walk-ins. The OIG learned the facility had two toxic exposure screening navigators, with the roles considered as additional duties. The navigators reported staffing as sufficient but also indicated that a dedicated full-time employee could assist with screenings and documentation and monitor toxic exposure screening data. Staff did not report any wait times for screenings.

In response to an OIG-administered questionnaire, a toxic exposure screening navigator confirmed, as of April 2024, staff had screened 73 percent of veterans actively enrolled at the facility. Staff reported conducting four outreach events in 2023 and scheduling six events for 2024. They advertised these events through social media, emails, and local press releases, as well as collaborative efforts with VSOs. Staff also distributed flyers with information about toxic exposures, screening, and the PACT Act.

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

In an interview, environment of care staff acknowledged challenges with maintaining an older building especially during winter weather conditions. Environment of care staff further stated that almost every area of the facility had been updated over the past 11 years. They also reported participating in daily huddles and updating leaders during morning meetings about what was

[44] 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.

[45] VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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

happening throughout the facility. The OIG found the facility met VHA's performance measure target for closing identified environment of care deficiencies or creating an action plan to address them within 14 business days. The OIG also found the environment of care team completed three performance improvement projects for FY 2023.[47]

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 several clinical and nonclinical areas throughout the facility and found all of them to be clean, with personal protective equipment readily available.[48] However, the OIG found an unlocked soiled utility room without a biohazard label on the door. Because staff corrected the issue during the site visit, the OIG made no recommendation.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[49] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[47] The performance improvement projects were 1) improving VA Police Services response time to behavioral issues in the Emergency Department; 2) developing and improving familiarity with the Environment of Care rounding checklist; and 3) ensuring all authorized employees are trained on the Lockout/Tagout procedures for energized equipment. Lockout/Tagout procedures protect staff from harm when using or conducting maintenance on machinery or equipment. "Control of Hazardous Energy (Lockout/Tagout)," Occupational Safety and Health Administration, accessed October 29, 2024, https://www.osha.gov/control-hazardous-energy.

[48] The OIG inspected the emergency department, a critical care unit, a medical/surgical inpatient unit, an outpatient clinic, and a community living center unit.

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

diagnostic and ordering provider teams and their patients.[50] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG found 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. The Chief of Staff reported the facility conducts quarterly internal audits related to communication of test results. The OIG reviewed the FY 2023 internal audit results and found the facility was at 91.7 percent compliance for the communication of test results.

The Chief of Staff and quality management staff identified a vulnerability related to test result alerts in the electronic health records that could potentially lead to alert fatigue.[51] The Chief of Staff stated the clinical application coordinators review the alert data and notify the providers' supervisors if they have not responded to the alerts. When this occurs, the supervisors notify the Chief of Staff, who in turn speaks with the providers about alert management and educates them on how to respond to alerts more efficiently. The Chief of Staff and quality management staff reported discussing alert fatigue during the weekly Patient Safety meeting as needed.

Action Plan Implementation and Sustainability

Figure 11. *Status of prior OIG recommendations. Source: OIG analysis of documents.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[52] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

Facility staff provided documentation that showed the facility did not have any open recommendations related to communication of test results. For oversight recommendations in general, quality management staff explained the Readiness Coordinator works with staff in the

[50] 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.

[51] 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.

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

applicable department to develop and implement an action plan for a specific recommendation and maintains a database of any open recommendations and action plans and tracks them to completion. Additionally, the Chief of Quality Management and quality management staff review open recommendations and action plans, report broad overviews of issues to facility leaders, and once a recommendation is closed, continue to monitor the changes for a year to ensure sustained improvements. The OIG did not identify any barriers to long-term improvements related to general patient safety.

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.[53] 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.[54] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In an interview, the Chief of Staff and quality management staff reported there were no process improvement initiatives being implemented related to the communication of test results. They added that facility leaders were supportive of improvement projects in general and shared process improvements with staff through patient safety meetings.

The Chief of Staff and quality management staff discussed the Innovation and Excellence Expo held at the facility in 2024. The Expo included 37 booths spotlighting innovations and opportunities for improvement across the facility and competing for awards in inpatient, outpatient, administrative, and fan favorite categories. The Chief of Staff and quality management staff gave examples of innovation projects that provided significant improvement in compliance, such as reviewing orders for antipsychotic medications for community living center residents and patients returning fecal immunochemical test kits. The fan favorite winner was an escape room where participants learned about HRO principles while trying to get out of the room.[55] The patient safety managers presented the escape room at the annual VHA National Patient Safety Symposium.

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

[54] VHA Directive 1050.01(1).

[55] An escape room is "a game in which participants confined to a room or other enclosed setting (such as a prison cell) are given a set amount of time to find a way to escape (as by discovering hidden clues and solving a series of riddles or puzzles)." *Merriam-Webster,* "Escape Room," accessed October 18, 2024, https://www.merriam-webster.com/dictionary/escape/room.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[56] 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.[57] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[58] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Through an OIG-administered questionnaire, staff reported the following primary care vacancies over the past 12 months: six providers, seven registered nurses, five licensed practical nurses, and four administrative assistants. In an interview, however, facility leaders stated they currently have two or three vacancies in each position. Despite the vacancies, the OIG found patients had timely access to care, with appointment wait times of approximately 1 to 2 days for established patients and 14 days for new patients.

Facility leaders reported recruitment and retention challenges for administrative assistants and licensed practical nurses. The leaders discussed difficulties finding administrative assistant applicants with scheduling experience but mentioned recent recruitment improvements, mainly due to referrals from current administrative assistants. For licensed practical nurses, leaders identified problems resulting from the lengthy hiring process, competitive private sector salaries, and limited nursing programs, particularly in rural areas such as Minot and Bismarck. To address these challenges, leaders stated they offered pay incentives and converted licensed practical nurse openings to registered nurse positions, as registered nurse positions were easier to fill.

To provide coverage when providers were on leave or vacancies occurred, facility leaders reported initially using staff from the clinical resource hub to provide coverage, but more recently developing a provider gap coverage pool that includes 4.5 full-time equivalent

[56] 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.

[57] 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).

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

providers. During interviews, primary care staff agreed that the gap coverage pool was reasonable and did not affect team functioning. Leaders reported that nursing and administrative staff worked together to provide coverage as needed.

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.[59] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[60]

In interviews, primary care teams reported the current panel sizes were reasonable and did not cause any concerns. Facility leaders stated the coordinator for the Patient Centered Management Module randomly assigns patients to panels and adjusts panel sizes with input from the primary care service chief and providers. Leaders added that they try to keep panel fullness at 92 percent and when it reaches 95 percent, they recruit a new provider or identify gap coverage.

The OIG noted the facility experienced a decrease in veteran enrollment from FY 2021 to FY 2023.[61] According to facility leaders, their service area, except the Minot area, experienced general population decline, which contributed to falling enrollments. Leaders noted an increase in veteran enrollment at the Minot Community-Based Outpatient Clinic, which created challenges with limited clinic space and staff to accommodate the demand. In response, leaders offered telework and compressed work schedules.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[62] 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 they found facility leaders to be responsive, and leaders worked within their abilities to resolve issues to improve efficiency and team functioning. Facility leaders reported several channels (e.g., emails, instant messaging, weekly meetings, quarterly town halls, and steering committee meetings) for staff to communicate their concerns and collaboratively develop solutions or elevate concerns to executive leaders when appropriate. Leaders retrained all primary care staff on VHA's primary care team model and how

[59] "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).

[60] VHA Directive 1406(1).

[61] Veteran enrollment was 42,898 in FY 2021; 41,832 in FY 2022; and 41,243 in FY 2023.

[62] VHA Handbook 1101.10(2).

to work within each discipline's roles and responsibilities, with the goal to complete training by the end of FY 2024.

Primary care staff and facility leaders identified a process improvement project implemented at the facility. Specifically, the primary care social workers established an education group for patients and caregivers to discuss planning for the future, including available VA services, assistance with aging in the home, and associated costs. A primary care social worker reported receiving positive feedback from group participants and planning to expand the group model to the community-based outpatient clinics.

Primary care leaders and staff identified the non-VA care consult management process as a barrier to efficiency. For example, staff explained that providers entered and managed non-VA care consults themselves, which reduced their efficiency. To address this, the Group Practice Manager stated that leaders hired nine registered nurse care managers to assist providers with consult management and to coordinate non-VA care. In addition, leaders developed a nursing subcommittee to review nurses' involvement in consult management and various nursing protocols.

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. To prepare for an anticipated increase in veteran enrollment, facility leaders stated they reviewed and adjusted panel sizes and hired additional staff. However, facility leaders stated they experienced a decrease in veteran enrollment and attributed it to a general population decline in the service area, as well as more veterans using care in the community options. To increase enrollments, facility leaders and staff reported engaging in PACT Act outreach and social media promotions. Primary care staff added that toxic exposure screening did not affect how the teams functioned or the timeliness of care.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[63]

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).[64] 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."[65]

From FYs 2021 to 2023, the facility's HCHV program exceeded VHA's performance measure target for HCHV5.[66] The staff attributed their success to creating and following an outreach schedule, tracking their efforts and outcomes, and accurately completing assessments. In reviewing the facility-provided tracker, the OIG noted staff reported 541 contacts between October 2023 and February 2024. In an OIG-administered questionnaire, staff stated the program's Coordinated Entry Specialist regularly met with community partners, including food banks, and reviewed community-maintained lists of unsheltered individuals within the facility's service area to follow up with those identified as veterans.

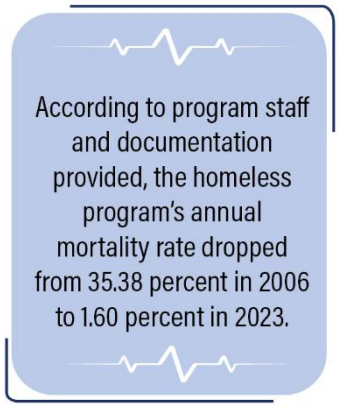


Figure 12. *Impact of homeless programs. Source: OIG analysis of an interview and document.*

In the Fargo area, the program had dedicated staff who worked with community partners to conduct outreach. In the outer lying areas, other homeless program staff located at the community-based outpatient clinics conducted outreach with community partners and served as the points of contact in their designated locations. Program staff reported a Fargo-based community coalition group had recently formed to enhance coordinated outreach activities between the facility's program and community partners. The group, including program staff, conducted outreach to homeless encampments and responded to referrals about individuals panhandling in the area. The staff explained that while participating in these coordinated outreach

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

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

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

[66] For the HCHV5 performance measure, VHA sets an escalating target each FY with the goal of reaching 100 percent by the end of the FY. The facility reported 137.50 percent for FY 2021, 115.63 percent for FY 2022, and 103.13 percent for FY 2023.

events, they engaged with unsheltered individuals, screened them to determine veteran status, and connected veterans to VA services.

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).[67]

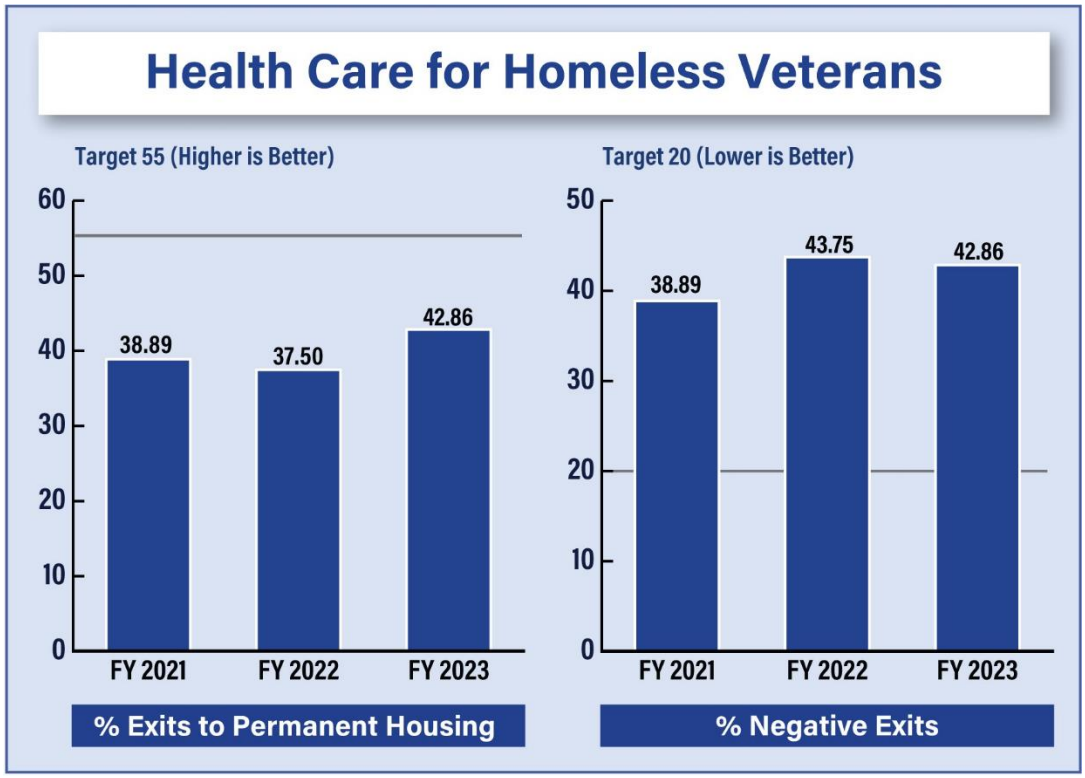


Figure 13. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The OIG noted program staff did not meet HCHV1 and HCHV2 performance measure targets between FYs 2021 and 2023. In an interview, staff explained they have only four contracted beds used for temporary housing; therefore, they can only discharge veterans from these four beds to permanent housing to meet the measure. Staff further reported that with the limited number of contracted beds, they tend to admit veterans based on need rather than attempts to meet the measure. Staff discussed additional barriers with veterans being discharged to permanent

[67] 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*.

housing, including being involved in the justice system, having a history of multiple evictions, owning pets, and having behavioral health problems.

The Homeless Program Manager reported that once they identify a veteran, they meet with the person, complete an assessment, develop treatment plans, and coordinate care and services between the facility and community partners. Staff suggested they could improve care coordination by working more closely with facility behavioral health staff and attending patient care meetings. To represent the program's and community's work to end homelessness, staff reported that the week prior to the OIG site visit, the service areas located near the two community-based outpatient clinics in Minnesota reached functional zero for the first time.[68]

The Homeless Program Manager reported using surveys to assess veterans' experiences throughout participation in the program. The surveys allowed veterans to provide feedback and suggestions about the program. Staff provided an example of meeting veterans needs by implementing a suggestion to increase access to laundry facilities at the Community Resource and Referral Center.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[69] 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.[70]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[71] The Veterans Justice Program met the performance measure target for FY 2023.[72] Through an interview and documents provided by program staff, the OIG learned the program consisted of one Veterans Justice Outreach Specialist and one Peer Support Specialist who provided services to veterans at three veterans treatment courts and 37 jails and

[68] Functional zero means a "community never has more veterans experiencing homelessness than it has demonstrated it can house in an average month." "Ending Veteran Homelessness in Virginia: A Statewide Collaboration." National Alliance to End Homelessness, November 8, 2018, accessed June 13, 2024, https://endhomelessness.org/resource/ending-veteran-homelessness-virginia-statewide-collaboration/.

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

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

[71] 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*.

[72] For the VJP1 performance measure, the facility reported 112 percent for FY 2023.

prisons, including two tribal jails, within 33 counties.[73] The OIG found the staff conducted outreach to community partners like legal aid, court staff, and VSOs, and to the facility's police and social workers. Program staff reported having formal relationships with the community partners that benefit veterans involved in the justice system. For example, the Burleigh County Detention Center, North Dakota Department of Corrections, and Ward County Jail allowed video appointments and in-person services; Legal Services of North Dakota offered civil legal services; and the Northeast Central Judicial District Court in North Dakota had established two veterans treatment courts. Staff further reported North Dakota passed a law that allowed any veteran seen in court the benefits and protocols of a veterans treatment court without a veterans treatment court being established in the local community.

Program staff further explained their responsibilities included educating community partners about the program through presentations and outreach. They also reported having points of contact in some jails and prisons who notify program staff when they encounter veterans; staff also said they attempted to expand their contact list by sending out program information and asking if the jails and prisons check for veteran status. Staff added that North Dakota Department of Corrections verified veteran status and provided a list of veterans to program staff every month, and staff attempted to meet with the veterans prior to their release. Program staff identified challenges in working across the two states and with different coordinators at three veteran treatment courts.

Many jail and prison telephone services did not support the use of automated phone menus, which prevented veterans in custody from being routed to program staff when calling the facility's main number. As a result of program staff developing positive relationships with jail and prison staff, they now include the Veteran Justice Outreach Specialist's cell phone number on their free phone call list for those incarcerated. The specialist identified some limitations to this service including the specialist being unable to respond to veteran calls outside of business hours.

Figure 14. *Meeting the needs of justice-involved veterans. Source: OIG interview.*

Meeting Veteran Needs

In response to a questionnaire, staff described goals for veterans in the program that included completing treatment court requirements, attending substance use or mental health treatment, connecting with VA and community services, and obtaining housing. The staff reported completing a psychosocial assessment for each veteran; then, based on the assessment, they identified appropriate VA and community services. Staff acknowledged a history of these

[73] "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 Program (VJP)*, September 27, 2017, amended March 3, 2020.

veterans encountering stigma when accessing care at the facility and identified a need for further education for staff throughout the facility about the program.

Program staff reported identifying and tracking veterans and attempting to meet any needs by conducting outreach and maintaining positive relationships with points of contact at jails and prisons. Additionally, program staff discussed formalizing a local law enforcement deflection team, as well as a Veterans Integrated Service Network (VISN)-level team to coordinate welfare checks and other services for veterans in need.[74] Also, a new facility program, Post Incarceration Engagement, connected veterans with services after release.

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."[75] 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.[76]

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).[77]

The OIG found the Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet the performance measure target for FYs 2022 and 2023.[78] In an interview, the OIG learned the program team consisted of six staff members located in Fargo and one staff member in each of the eight community-based outpatient clinics. Staff also provided services to two tribal nations. Staff stated they worked across three states and with 14 housing authorities,

[74] A deflection team is a "multidisciplinary group [that] serves as a bridge between first responders and the VA by facilitating timely notifications about Veterans that could benefit from mental health support, substance abuse treatment, or assistance navigating the justice system." Department of Veterans Affairs," JAHVH [James A. Haley Veterans' Hospital] Deflection Team and Tampa First Responders Partner to Help Veterans," https://www.va.gov/tampa-health-care/deflection-team-and-tampa-first-responders-partner-to-help-veterans/.

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

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

[77] VHA sets the HMLS3 and 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*.

[78] For the HMLS3 performance measure, the facility reported 71 percent for FY 2022 and 66 percent for FY 2023.

and described a dashboard they developed to track their 300 housing vouchers across locations: 150 housing vouchers were assigned to the Fargo area (utilization rate of 93 percent) and 150 vouchers assigned to the community-based outpatient clinic areas (utilization rate of 70 percent) and the tribal communities (utilization rate of 65 percent). The staff reported helping veterans use the vouchers but explained they rarely meet the performance measure target because of the program's rural locations and multiple sites. They further described constantly reviewing processes and discussing what more they could be doing.

Program staff also reported working with their community partners to identify homeless veterans. Once identified, staff completed a psychosocial assessment to determine their needs and secure housing. Staff stated the Fargo-based staff worked in teams of two to address veterans' needs and found this approach reduced burnout. Because only one staff member worked at each community-based outpatient clinic, these staff worked closely with community partners to create a team approach.

Staff discussed challenges in finding affordable housing, one-bedroom apartments, and housing for sex offenders. They described working with one of the largest landlords in the area to remove application fees and appeal denied applications. Further, staff stated that when case managers were involved, landlords were more willing to accept veterans even with barriers like a history of evictions.

A town located between the Williston and Dickinson, North Dakota, outpatient clinics did not have an assigned Housing and Urban Development-Veterans Affairs Supportive Housing program staff member. To meet veterans' needs, staff at those clinics collaborated with the local housing authority to secure housing.

Figure 15. *Veteran engagement. Source: OIG interviews.*

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).[79] The OIG found the program met the performance measure target for FYs 2022 and 2023.[80] In an interview, program staff reported consistently meeting this performance measure because of the program's Employment Coordinator, who updated veterans' employment status and worked with local job services to identify employment opportunities. In one case, the coordinator met with a veteran who had difficulty sustaining employment, learned the veteran enjoyed crafting, and helped the veteran find a position at a local crafting store.

[79] 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*.

[80] For the VASH3 performance measure, the facility reported 75.38 percent for FY 2022 and 80.77 percent for FY 2023.

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 seven 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 May 20 through May 23, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[2] The OIG received responses from three VSOs: Disabled American Veterans; North Dakota Department of Veterans Affairs; and North Dakota Department of Veterans Affairs, Womens Veteran Coordinator.

[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.

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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 29, 2024

From: Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Facility Inspection of the Fargo VA Health Care System in North Dakota

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

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

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection of the Fargo VA Health Care System. I concur with the facility and the report as presented.

(Original signed by:)

Robert P. McDivitt, FACHE
Executive Director, VA Midwest Health Care Network (VISN 23)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 22, 2024

From: Interim Director, Fargo VA Health Care System (437)

Subj: Healthcare Facility Inspection of the Fargo VA Health Care System in North Dakota

To: Director, VA Midwest Health Care Network (10N23)

I fully agree with the report as presented. Our facility appreciates the Office of Inspector General for their efficiency and the valuable time they dedicated to us here in Fargo.

(Original signed by:)

Rod Gellner, MA, RN

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