US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Poplar Bluff Health Care System in Missouri

Healthcare Facility Inspection	24-00608-46	January 15, 2025

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

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Poplar Bluff Health Care System from June 24 through 27, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. In an interview, executive leaders identified frequent turnover in key leader positions and challenges in working with local union leaders as system shocks. At the time of the site visit, the facility director and associate director positions were filled by an interim and acting staff member, respectively. Leaders stated that previous directors had held the position on average 15 months, which limited their opportunities to make any significant changes. Leaders also reported receiving several unfair labor practice claims and grievances and multiple emails from local union leaders, which were time consuming to address. The OIG made two recommendations to address these system shocks.

The OIG also reviewed the results of the VA All Employee Survey and found scores had increased across various areas, including communication and information sharing, diversity, best places to work, supervisory trust, and psychological safety. Staff reported leaders had improved their communication efforts and the information was clear and useful. Staff also reported they

[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.

felt empowered to make suggestions for further improvement and agreed the culture of the facility was moving in the right direction. Although the facility did not meet VA's target for employing veterans, the OIG found that leaders prioritized diversity and inclusion through special events and staff-driven cultural activities.

In responses to OIG-administered questionnaires, veteran service organizations and the facility's Patient Advocate indicated they could provide feedback to leaders about veterans' care, and leaders were responsive to their concerns.

Environment of Care

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

The OIG found the facility to be generally clean and well-maintained, with sufficient parking and a welcoming main entrance. The facility greeters and volunteers located at entrances provided directions and answered questions, and the OIG learned that staff included facility maps in appointment reminders sent to veterans. During environment of care inspections, the OIG found 10 nonoperational security cameras. Following the OIG site visit, facility leaders provided documentation that an outside agency had evaluated the cameras, and they were waiting on pricing quotes before replacing or repairing them. The OIG made one recommendation regarding the security cameras.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; 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 comprehensive processes for communicating test results, and staff regularly reviewed the related data and had not identified any major concerns or delays. Through interviews, the OIG learned the facility had no barriers to improvements and leaders supported process improvement projects. At the time of the inspection, the facility had no open recommendations from oversight reports.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation

affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[2]

Although the facility had shortages of all core team members and staff reported experiencing burnout, the OIG found patients did not experience increased appointment wait times or delays in care. However, there were severe shortages among primary care social workers, who said they could address only urgent needs rather than working closely with patients to establish care plans. VHA suggests staffing ratios of one social worker for every two primary care panels; however, the facility had two social workers covering over 20 panels, with one of them assigned additional responsibilities.[3] The OIG made one recommendation related to staffing.

The OIG also examined what measures facility leaders employed to assist with efficiency and how they supported primary care team functions. The OIG found that space limitations within the main primary care area prevented staff from having individual workstations or privacy when speaking with patients. Although facility leaders said they were aware of the situation, the OIG requests the Director identifies possible ways to improve clinic workflow.

The OIG also found primary care staff and leaders had different points of view on various subjects, which indicated ineffective communication processes. For example, staff stated they requested to participate in meetings involving primary care related issues but received no response about their request. However, facility leaders stated they held several weekly and monthly meetings with primary care staff to discuss concerns and incorporated some of their suggestions on how to address them.

The leaders also provided the OIG with documents outlining various meetings held between the leaders and primary care staff, which included discussions on how to improve communication. Based on the differing views between primary care staff and facility leaders, the OIG requests the Director reviews primary care communication processes and identifies opportunities for improvement.

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 programs with a strong emphasis on outreach services and connections with multiple community partners. Across the programs, staff identified two barriers in meeting veterans' needs: lack of affordable housing and limited transportation. Leaders

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

[3] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

planned to recruit new landlords to increase housing options, and staff helped veterans arrange transportation and apply for VA and social security benefits.

Homeless program staff highlighted a Community Living Group where they discuss resources, such as housing and employment, with veterans to help them prepare for permanent housing. Staff added the VA Central Office recognized the program for ranking as one of the highest in the nation for helping veterans obtain permanent housing.

What the OIG Recommended

The OIG made four recommendations.

1. The Veterans Integrated Service Network Director takes actions to ensure stable and consistent leadership at the facility.
2. The Veterans Integrated Service Network leaders assist facility leaders to improve interactions with local union leaders.
3. The Interim Medical Center Director ensures all security cameras are operational.
4. The Interim Medical Center Director ensures primary care teams are staffed according to VHA guidelines.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Interim Medical Center Director concurred with recommendations 3 and 4, concurred in principle with recommendations 1 and 2, and provided acceptable improvement plans (see appendixes C, D, and E for a full text of the directors' comments). Based on information provided, the OIG considers recommendations 1 and 2 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

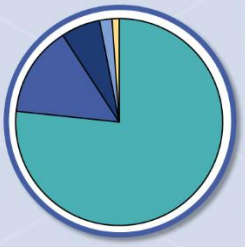
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

VA Poplar Bluff Health Care System
Poplar Bluff, Missouri
Level 3-Low Complexity Facility
Butler County
Hospital Referral Region: St. Louis

Description of Community

RACE AND ETHNICITY



- White 76%
- Black 14%
- Two+ 6%
- Asian 2%
- Other 1%
- Native 0%
- Islander 0%

MEDIAN INCOME

$51,348

EDUCATION

87% Completed High School
58% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **244**

POPULATION

Female **2,008,363**
Male **1,943,221**
Veteran Female **27,402**
Veteran Male **240,655**

Homeless - State **5,992**
Homeless Veteran -State **476**

UNEMPLOYMENT RATE

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

SUBSTANCE USE

26.3% Driving Deaths Involving Alcohol
19.8% Excessive Drinking
1,421 Drug Overdose Deaths

TRANSPORTATION

Drive Alone	1,512,895
Carpool	144,434
Work at Home	122,921
Walk to Work	36,566
Public Transportation	28,717
Other Means	20,609

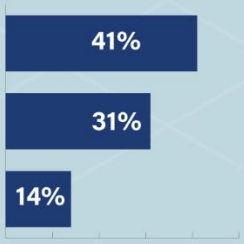
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**31 Minutes, 27 Miles**
Specialty Care	**58 Minutes, 55 Miles**
Tertiary Care	**84 Minutes, 85 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **6,039**



Veterans Receiving Teleheath (VHA)	41%
Veterans Receiving Telehealth (Facility)	31%
<65 without Health Insurance	14%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

5,295

3 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.68 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
24	45

Health of the Facility

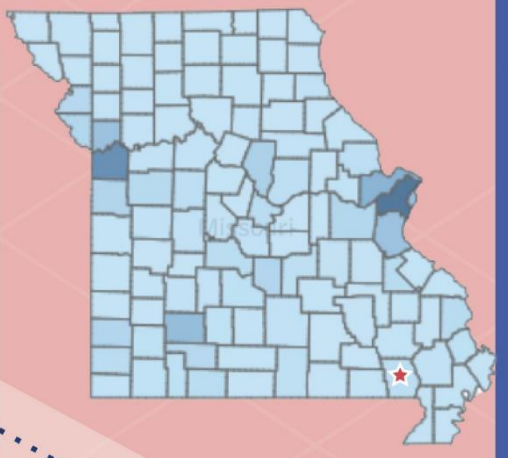
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	24K
Unique Patients VA Care	22K
Unique Patients Non-VA Care	17K

★ VA MEDICAL CENTER

VETERAN POPULATION

149 — 54,371



COMMUNITY CARE COSTS

Unique Patient $16,504	Outpatient Visit $273
Line Item $565	Bed Day of Care $228

STAFF RETENTION

Onboard Employees Stay <1 Yr	N/A
Facility Total Loss Rate	N/A
Facility Retire Rate	N/A
Facility Quit Rate	N/A
Facility Termination Rate	N/A

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

Contents

Background and Vision

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

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

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

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

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

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

High Reliability Organization Framework

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

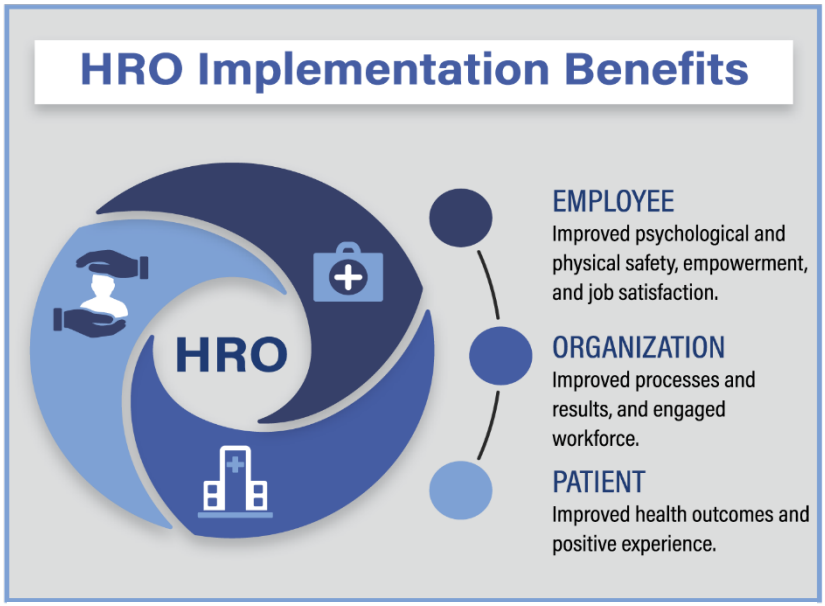


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

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

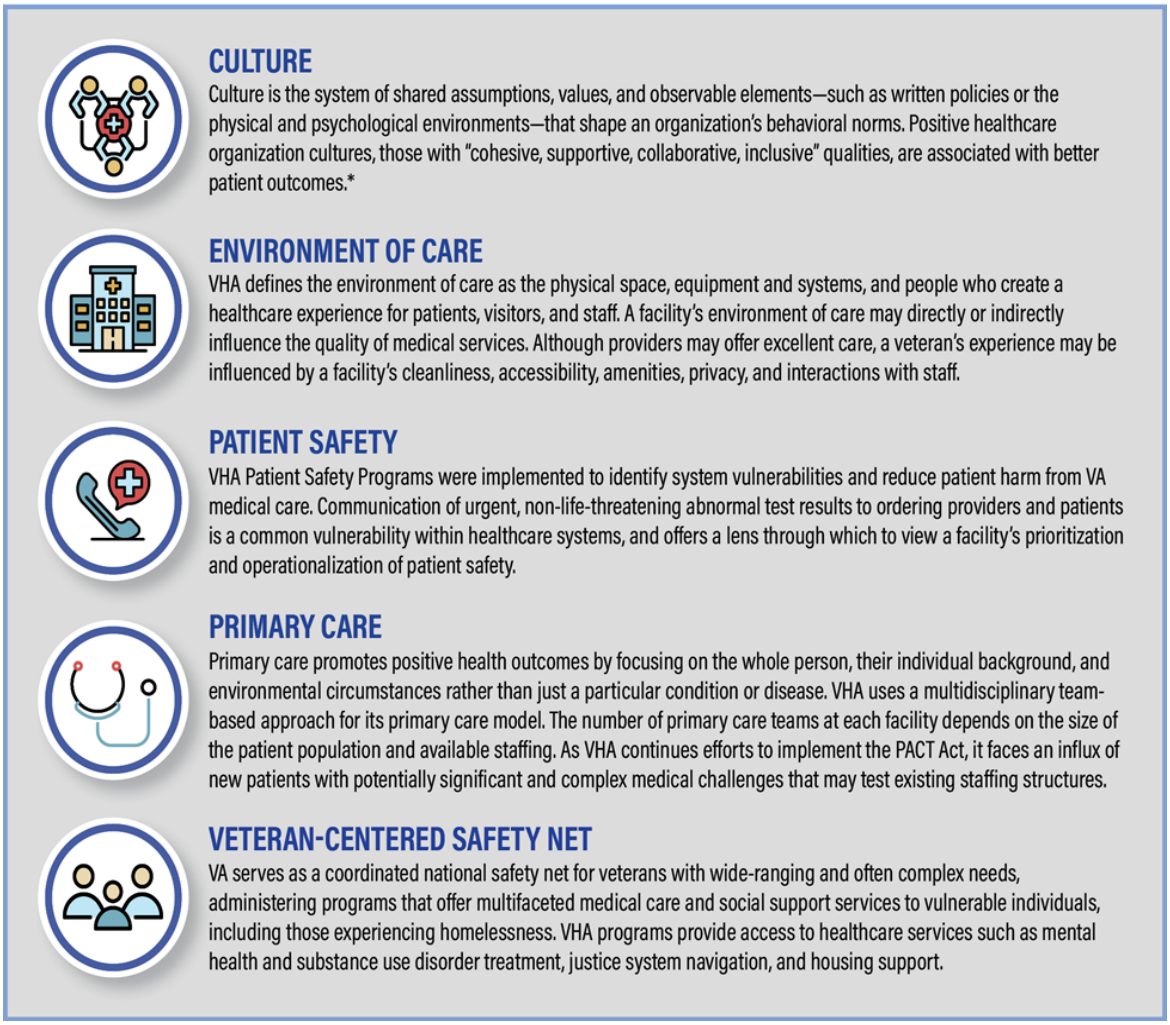


Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight 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.

Based on information provided to the OIG, the VA Poplar Bluff Health Care System (facility) began caring for veterans in 1951.[13] At the time of the inspection, the facility's executive leaders consisted of an Interim Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Services, and an Acting Associate Director. Based on interviews, the Chief of Staff had been in the position for three years, and the Associate Director for Patient Care Services since 2017. In fiscal year (FY) 2023, the facility's budget was $366,965,577. The facility provided care to 23,510 veterans in FY 2023 and has 50 operating beds (10 hospital and 40 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 VA Poplar Bluff Health Care System includes the John J. Pershing VA Medical Center located in Poplar Bluff, Missouri, and a healthcare center located in Cape Girardeau, Missouri. The facility has five community-based outpatient clinics located in Farmington, Sikeston, and West Plains, Missouri; and Paragould and Pocahontas, Arkansas.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/health-care/about-va-health-benefits/long-term-care/.

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

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

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

System Shocks

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

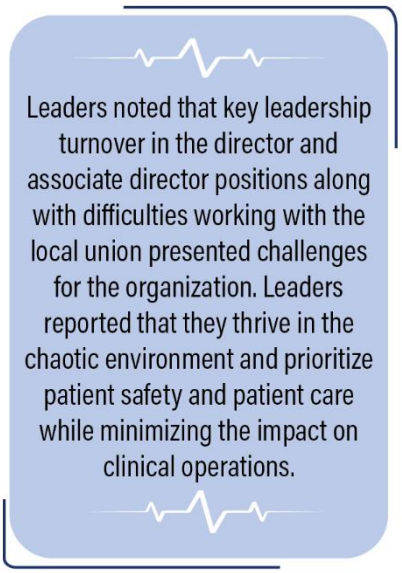


Figure 4. *Facility system shocks. Source: OIG interviews.*

In an interview, the facility's executive leaders discussed several system shocks that affected the organization's culture, including frequent turnover in key leadership positions and challenges in working with the local union leaders.[20] Leaders reported that previous medical center directors served in the positions on average 15 months. They attributed the turnover rate to the facility being low volume, with low-risk patients and few complex programs, which may provide experience to new leaders for positions at more complex facilities. At the time of the site visit, the leaders reported having an interim director for the past four months, and an acting associate director for the past three months. Leaders stated that the turnover limited opportunities to make any significant changes.

In addition, leaders reported receiving several unfair labor practice claims and grievances as well as multiple emails from local union leaders. Leaders explained that addressing the union activities was time consuming. Facility leaders described meeting frequently with local union leaders to try to bridge communication gaps and build trust. Leaders stated they consulted with Veterans Integrated Service Network (VISN) and VA leaders about the issues.[21]

The OIG found that facility leaders responded to each of these system shocks to the best of their ability, but they need assistance. Therefore, the OIG recommends the VISN Director take actions

[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] Generally, the union represents federal agency workers through numerous locally established units.

[21] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

to ensure stable and consistent leadership at the facility. The OIG also recommends that VISN leaders assist facility leaders to improve interactions with local union leaders.

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]

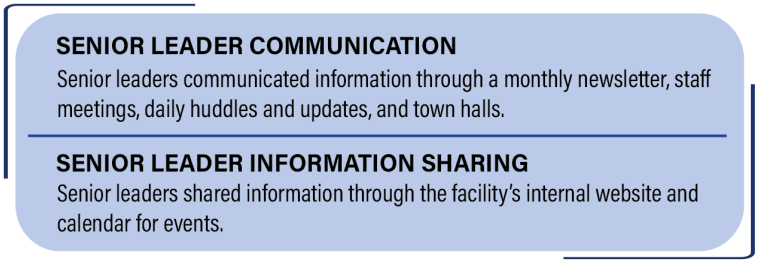


Figure 5. *Leader communication with staff.*
Source: OIG interviews with facility leaders.

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]

The All Employee Survey scores for senior leaders' communication, information sharing, and transparency consistently improved from FYs 2021 to 2023. Facility leaders stated they were aware of the scores and increased their efforts to communicate frequently and transparently with all staff. The leaders engaged in daily tiered huddles to ensure all staff received timely information and used town halls, newsletters, and an internal website to further communicate throughout the organization.[26] The OIG questionnaire showed staff largely agreed that leaders had made changes to how they communicated information, the changes were an improvement, and the information was clear and useful.

[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." "VA All Employee Survey," VHA National Center for Organization Development.

[26] Tiered huddles, involving frontline staff to senior leaders, are brief, focused meetings used to share information, identify possible problems, address staffing levels, and allocate resources. Naseema B. Merchant et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000/.

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.

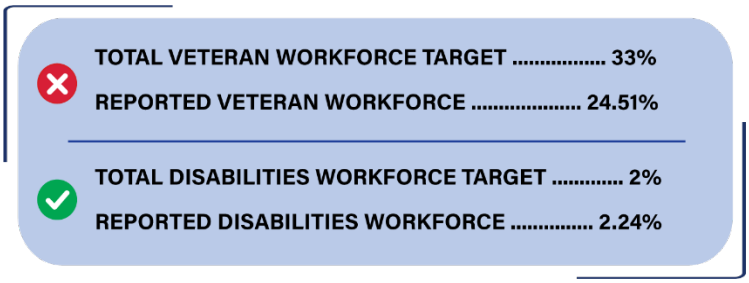


Figure 6. *Facility workforce diversity.*
Source: Facility human resources data.

The OIG reviewed human resources data and found the facility met the VA target for employing individuals with disabilities but did not meet the target for veterans (see figure 6). All Employee Survey scores related to workplace diversity indicated employees perceived diversity as having improved from FYs 2022 to 2023.

[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/IncreasingVAWorkforceDiversity_June2023_FINAL.pdf.

According to information employees provided to the OIG, they hosted several special emphasis events related to diversity and inclusion in calendar year 2023.[31] The executive leaders confirmed employees participated in several of these events, including a Hispanic heritage celebration, the Martin Luther King Jr. Day observance, and the Annual Federal Inter-Agency Holocaust Remembrance Program. In addition, leaders mentioned the success of some employee-driven diversity and inclusion activities, such as sharing culturally specific recipes and demonstrating cultural music and dance. Leaders informed employees of events and encouraged participation via emails, newsletters, and overhead announcements. The OIG found that leaders were committed to prioritizing diversity and inclusion through collaboration and special emphasis events.

[31] The special emphasis events focused on a federal women's program; sexual orientation and gender identity groups; and African American and Black, Hispanic, Native American, Arab American, Pacific Islander and Asian American employment programs.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[32] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[33]

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.

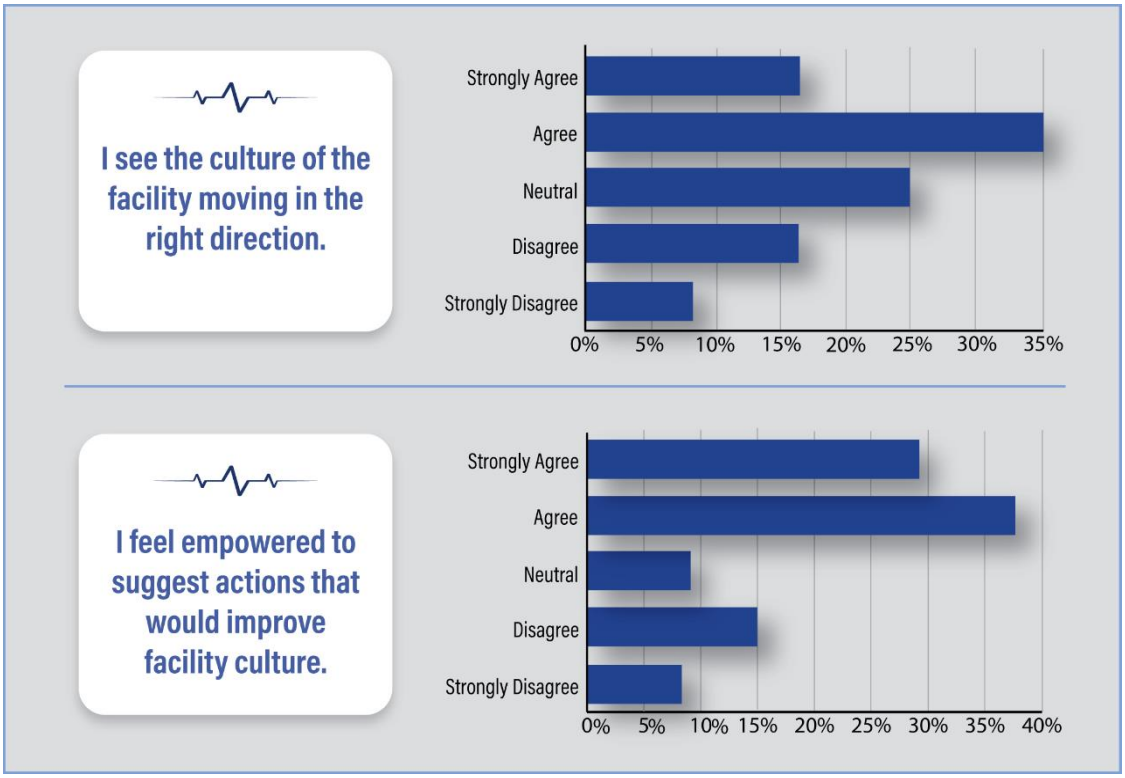


Figure 7. *Employees' perceptions of facility culture.*
Source: OIG questionnaire responses.

The OIG found All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety had increased from FYs 2022 to 2023. Facility leaders attributed the improvement to increasing staffing levels and their visibility through frequent visits and interactions with employees in various areas throughout the organization. In addition,

[32] 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.

[33] 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.

leaders said employees reported more safety events and shared more stories during safety forums, indicating improved psychological safety.

In the OIG-administered questionnaire, respondents largely indicated that pay and benefits, followed by the VA mission, kept them at the facility, whereas stress and burnout were listed as reasons they might leave. Leaders stated they invested in the employee experience by implementing wellness activities like massage chairs and yoga and offering several employee programs to improve the overall culture, including the Whole Health Program.[34] Additionally, employees have access to a gymnasium, walking track, and portable exercise equipment that can be used at their desks.

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 response to an OIG-administered questionnaire, the Patient Advocate noted the most common complaints from veterans were billing concerns, late medication deliveries, and providers' rudeness. The Patient Advocate indicated there were specific mechanisms for veterans to provide direct feedback to facility leaders, and that leaders were responsive to veterans' concerns. Facility leaders reported the Patient Advocate tracks all complaints and their resolutions.

The Director described meeting monthly with VSOs to share information. Three VSOs responded to the OIG questionnaire asking for feedback about working with the facility and the PACT Act's implementation.[37] VSO respondents reported they could provide feedback to facility leaders about care provided to veterans, and the leaders were responsive to the veterans' concerns. However, one respondent noted that the constant change in facility directors causes instability.

[34] "Whole Health is VA's approach to care that supports your health and well-being." "Whole Health," Department of Veterans Affairs, accessed March 25, 2024, https://www.va.gov/WHOLEHEALTH/index.asp.

[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] See appendix A for further details on the VSO respondents.

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 8. *Facility photo.*
Source: "John J. Pershing Veterans' Administration Medical Center," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/poplar-bluff-health-care/locations.

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.

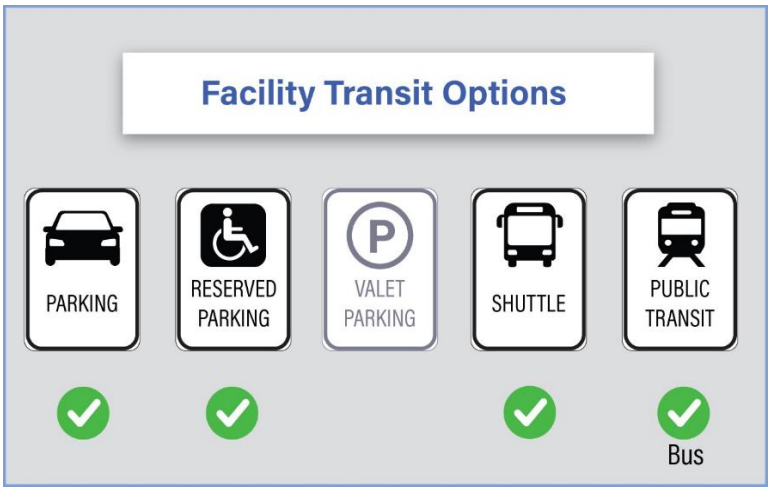


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

Using the navigation link located on the facility's public website, the OIG obtained directions directly to the main entrance. The OIG found numerous, well-lit parking lots, which included general, accessible, and Purple Heart recipient parking spots. In addition, staff explained that public transit buses stopped at the facility every 30 minutes during working hours Monday through Friday.

VA police stated they conduct car or foot patrol 24 hours a day, seven days a week and use 39 security cameras to monitor the parking lots and facility. However, 10 of the cameras became inoperable after a storm. Prior to the OIG site visit, VA police had not informed leaders about the inoperable cameras. On July 10, 2024, approximately two weeks after the site visit, the OIG received a copy of a facility memorandum between the Chief of Police and the Acting Assistant Medical Center Director explaining that an outside company had evaluated the cameras, and leaders were waiting on pricing quotes before replacing or repairing them. The OIG recommends the Interim Medical Center Director ensures all security cameras are operational.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[41] The OIG noted the main entrance to the facility was well marked by signage in the driveway, in the parking lots, and on the main building. At the main entrance, the OIG

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

[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*.

observed a patient loading zone with an overhang to shelter veterans and visitors, and an even-surfaced ramp and steps.

The OIG team entered the facility through a set of power-assisted doors and was welcomed by a greeter. Once inside, the OIG found the main entrance was an open, well-maintained, and well-lit space. Although the lobby was small, seating was available. The facility did not offer a café but did have a small canteen and store combination on the second floor of the main building.

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 found that, in addition to the facility greeter, volunteers were present at the information desks located at all entrances and provided directions and answered questions. The OIG also observed maps and directories hung throughout the facility and near elevators. In addition, staff told the OIG that approximately 16 to 18 months previously, they began including maps in appointment reminders. The facility also had newly installed electronic signs at the main entrance that advertised what was happening at the facility, including situations that affected patient care.

The OIG found the facility was undergoing construction on a medical-surgical unit (3B) in the main building. Facility staff told the OIG they used a coded door lock and signage to secure the construction site, and two weeks before the work began, posted signs on the unit informing staff and veterans about the upcoming project.

The OIG also evaluated whether facility navigational cues were effective for

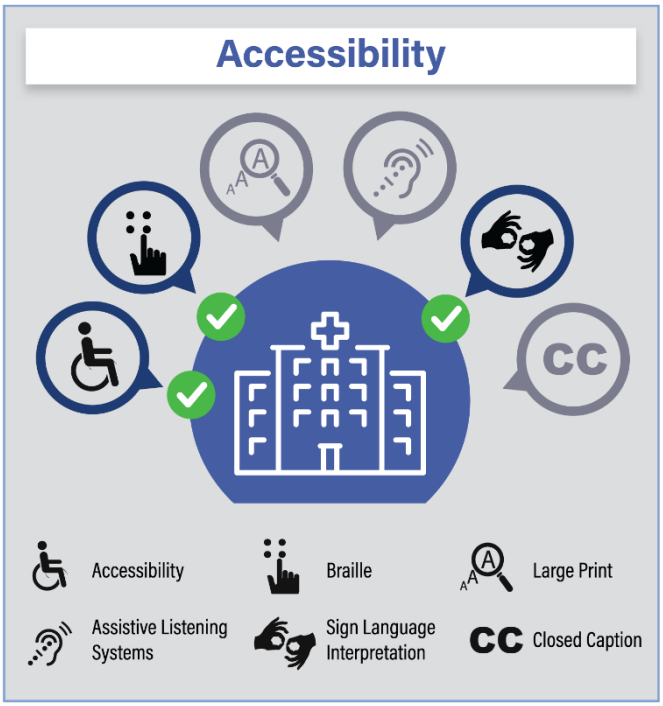


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations and analysis of documents.

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

veterans with visual and hearing sensory impairments.[43] The OIG found no complaints to the Patient Advocate's office about accessibility problems among veterans with sensory impairments. During a walk-through inspection, the OIG confirmed the presence of braille on signs located throughout the facility. Although staff at the information desk were not able to communicate using sign language, they said they would escort veterans to their requested locations. Per a facility memorandum dated May 30, 2024, staff and volunteers received information about offering sign language interpretation through a contracted service as needed.

Toxic Exposure Screening Navigators

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

Based on responses to the OIG-administered questionnaire, the facility had two toxic exposure screening navigators. However, the role was considered an additional duty, and the navigators said the position was not clearly defined. Most veterans received toxic exposure screenings during scheduled appointments, and the navigators completed screenings when veterans did not have an assigned primary care provider. Additionally, staff reported holding multiple events over the past 12 months to educate veterans about the PACT Act and toxic exposure. Primary care teams received informational flyers and handouts about toxic exposure and the PACT Act to share with veterans.

Based on documentation provided to the OIG, staff tracked screenings using the VHA-wide Toxic Exposure Screening Report. As of May 29, 2024, staff had completed 19,325 initial screenings, with 8,725 veterans identifying at least one exposure concern; 13 veterans needed a secondary screening (conducted when veterans report a toxic exposure during the initial screening).

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.[45] The OIG analyzed facility

[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.

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

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

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

The OIG found the facility met VHA's performance targets for closing identified environment of care deficiencies or creating an action plan to address them within 14 business days, except for FY 2024, quarter three. The Environment of Care Rounds Coordinator reported completing the action plans; however, attributed being delinquent for the one quarter to being on leave. Staff identified stained ceiling tiles as a repeat finding during environment of care rounds and explained that when they found a stained tile, they replaced it, then looked for and repaired the underlying cause of the problem.

General Inspection

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

The OIG inspected clinical and nonclinical areas throughout the facility and the community living center.[46] The OIG found the facility to be generally safe and clean, with patients' privacy maintained. There were clear exit paths and patients were able to move easily. All inspected medical equipment had current inspection stickers, and no protected patient information was visible. Facility staff generally complied with requirements for disposing expired, damaged, and contaminated medications; identifying biohazard waste; and restricting access to supply rooms. In the medical-surgical unit, the OIG found one refrigerator door with dirty shelves, as well as bags of donated blankets and decorations on shelves in the clean supply room. Staff immediately addressed both problems. The OIG also found the main entrance of the community living center to be warm and welcoming, with a homelike environment. In a small kitchenette available for resident use, the OIG observed food items placed in bags with names and dates stored in the refrigerator.

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of

[46] The OIG inspected the urgent care center, a medical-surgical inpatient unit, an outpatient clinic, and a unit in the community living center.

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.[47] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[48] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined the facility had processes to communicate abnormal test results to ordering providers, identify a designee when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours. In an interview, the Chief of Staff explained that primary care providers were responsible for communicating test results after the patient was discharged from an inpatient unit and urgent care, unless it was a critical result, which went through an escalation process. The facility used a contracted provider to manage all critical results received during off-duty hours.

The OIG found facility staff monitored data related to communication of test results. Staff reviewed and discussed the quarterly External Peer Review Program communication of test results data, and the Chief of Staff and quality management staff did not identify any major concerns or delays.[49] The Chief of Staff and quality management staff stated that beginning in October 2023, the informatics team pulled test result alert data weekly to identify providers with unaddressed alerts. If they identified a provider with unaddressed alerts, the informatics team notified the service chief.

The Chief of Staff and quality management staff stated providers may experience alert fatigue due to the volume of alerts they receive daily, which could result in patient safety issues.[50] The Chief of Staff said clinical application coordinators trained providers on how to manage alerts

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

[48] 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.

[49] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

[50] 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.

and included the training in new employee orientation. The chief added that national leaders were also addressing alert fatigue.

Action Plan Implementation and Sustainability

Figure 12. *Status of prior OIG recommendations. Source: OIG analysis of a document.*

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

The facility had no open recommendations related to communication of test results from the previous three years. The OIG found 17 closed recommendations, unrelated to communication of test results, from an OIG report dated July 9, 2020.[52] When the facility has open recommendations, the Chief of Staff and quality management staff explained that service administrative officers and quality management staff monitor them by tracking action plans to completion and providing quarterly updates at department meetings. They further reported that accreditation and quality management staff review previous findings and provide an overview of actions taken during town halls. 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.

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

[52] VA OIG, *Comprehensive Healthcare Inspection of the John J. Pershing VA Medical Center in Poplar Bluff, Missouri*, Report No. 19-09416-186, July 9, 2020.

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

[54] VHA Directive 1050.01(1).

The Chief of Staff and quality management staff described using various methods to identify opportunities for improvement, including trackers, huddles, and staff-generated ideas. A recent staff-generated idea was adding "No Emergency Care–Only Urgent Care" to signs near the facility entrance to notify veterans that the facility does not provide emergency care. Another process improvement project involved providing patients with an after-visit summary report that includes what was discussed during the appointment and any changes to their medications, which has enhanced patient satisfaction.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[55] 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.[56] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[57] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, facility leaders and primary care staff stated the Primary Care Service had shortages of providers, registered nurses, licensed practical nurses, administrative associates, and social workers. Although the shortages did not affect appointment wait times or cause delays in care, staff told the OIG they experienced burnout due to increased workload and disruption in clinic workflow. Through interviews, the OIG learned the facility had float providers and nurses to assist with coverage when staff were on leave or there was a vacant position. Currently, the facility had three float registered nurses covering vacant positions. Staff reported that during morning huddles, their managers discussed coverage and reassigned staff as needed. In an interview, leaders reported difficulty recruiting licensed practical nurses in West

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

[56] 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).

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

Plains. They attributed the problem to the remote location and are unaware if there are any colleges that offered nursing programs in the area.

The OIG found the facility was severely understaffed for primary care social workers. VHA states that primary care "staffing must be sufficient to ensure that all patients assigned to the patient panel receive appropriate and desired health care."[58] VHA further suggests staffing ratios of one social worker for every two primary care panels.[59] The OIG found the facility had two social workers covering over 20 primary care panels, with one of them assigned additional responsibilities. The primary care team members reported the lack of social workers had not affected patient care; however, the social worker interviewed asserted they were mostly addressing urgent needs rather than working with patients proactively on their plans of care. From documentation provided by the facility liaison on July 19, 2024, the OIG learned that leaders planned to post a job announcement for a third social work position but acknowledged the difficulty in recruiting social workers throughout their service area. The OIG recommends the Interim Medical Center Director ensures leaders staff primary care teams according to VHA guidelines.

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.[60] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[61]

The OIG reviewed facility-provided documents and found that 13 of the 26 primary care team panels were less than 80 percent full. In an interview, the Chief of Staff stated they were working with VISN leaders to decrease community care referrals for primary care services and to increase panel fullness. In addition, primary care leaders reported realigning primary care panels so patients would be more evenly distributed.

Primary care staff stated that panel sizes, alone, were not the biggest concern. Staff expressed other concerns such as changes in consult processes. For example, staff reported learning a few months previously that nursing staff could no longer help providers prepare certain consults because it was outside their scope of licensure. This change caused disruptions and delays in clinic workflow because the providers were now solely responsible for entering consults, which staff explained was time consuming and involved multiple steps. In response, leaders stated they were working with VISN staff to create nursing protocols related to consult management. The

[58] VHA Handbook 1101.10(2).

[59] VHA Handbook 1101.10(2).

[60] "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).

[61] VHA Directive 1406(1).

protocols would provide guidance on which consults nurses could prepare and how to enter the information.

Staff also expressed concerns about limited clinic space, emphasizing the limited space caused them to lack individual workstations and privacy to speak with patients. Leaders acknowledged space challenges at the Farmington and main facility clinics. In Farmington, leaders plan to build a large multispecialty clinic to help alleviate space constraints. At the main facility, leaders acknowledged primary care space was limited because frequently referred subspecialties were embedded within the primary care area. The OIG requests the Director reviews the main facility's primary care layout to identify possible modifications that might improve clinic functioning and efficiency.

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.

Primary care staff reported being aware of only one process improvement project related to clinic workflow or efficiency, which was providing pharmacy services to patients diagnosed with chronic obstructive pulmonary disease who did not have an assigned pulmonologist. Staff stated they would like to participate in process improvement projects if given the opportunity but due to limited staffing, it would be difficult to participate without leadership support.

Primary care staff reported a lack of communication with facility leaders above their supervisor. Primary care staff said they follow the chain of command and report concerns to their direct supervisors but received no response from facility leaders. For example, staff requested to participate in meetings involving primary care related issues, but they received no response about their request. However, facility leaders stated they held several scheduled weekly and monthly meetings with primary care staff to discuss concerns. Leaders added that they had incorporated some suggestions received from staff, such as ways to improve documentation and training on alert management.

In documentation provided to the OIG on July 19, 2024, facility leaders outlined the various meetings held between the leaders and primary care staff, which included discussions on how to improve communication. Further, staff reported frequent turnover in primary care positions over the past two years and said it was no longer a place people want to work, whereas leaders asserted nursing staff were eager to work in primary care. Based on the interviews with primary care staff and leaders, the OIG found differences between how staff and leaders viewed primary

[62] VHA Handbook 1101.10(2).

care and their interactions. The OIG requests the Director reviews primary care communication processes, discusses staff concerns, and identifies opportunities for improvement.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that veteran enrollment rates decreased from FY 2020 through FY 2023. In interviews, leaders reported higher appointment wait times in the first four months after adding toxic exposure screenings. Staff have since described toxic exposure screening as a great tool and said its addition did not affect staff or clinic workload.

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

[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.

Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[65]

The facility's HCHV program did not meet the HCHV5 target in FY 2022 but did in FY 2023.[66] In an interview, program staff were unable to identify factors that contributed to the program falling short in FY 2022. However, staff said the program received two new staff members, the Coordinated Entry Specialist and Outreach Coordinator, who may have helped them meet the target in FY 2023. The Coordinated Entry Specialist explained that program staff participated in the point-in-time count and a yearly stand down event with community partners, and the Outreach Coordinator attended monthly events in rural areas.[67] Additionally, staff conducted outreach to encampments, wooded areas, shelters, police stations, libraries, and warming centers.

In 2019, homeless program staff implemented a weekly Community Living Group at VA contracted shelters in the facility's service area. The group prepares veterans for permanent housing by discussing budgeting, housing, employment resources, nutrition, and suicide prevention. The VA Central Office recently identified the Community Living Group model as a best practice and recognized the program for consistently ranking as one of the highest in the nation for permanent housing placements.

Figure 13. *Description of Community Living Group. Source: OIG interviews.*

Program staff also said the point-in-time count occurred twice per year, with the unsheltered count held at the end of January and the sheltered count happening in the fall. Staff explained they thought the count accurately captured the number of sheltered homeless individuals, but the count of unsheltered veterans in January may be less accurate due to veterans seeking shelter during the cold winter weather.

Program staff explained their process for enrolling veterans into the HCHV program. After receiving referrals, staff assess veterans for eligibility and appropriateness to participate in the program and determine if they have urgent or immediate housing needs. The Outreach Coordinator explained that homeless veterans often do not have the necessary documentation to verify their identity and eligibility, which may delay program enrollment. However, the coordinator assists veterans by ordering their military service records. As of September 2023, program staff advised that the facility no longer operated an urgent care center 24 hours a day, seven days a week. Therefore, the program had an agreement with a local hospital to provide

[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.

[66] For the HCHV5 performance measure, the facility reported 73.17 percent for FY 2022 and 107.32 percent for FY 2023.

[67] Stand downs are typically one- to three-day events that provide homeless veterans with housing assistance, food, health screenings, and referrals to VA programs and community resources. VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services,* February 18, 2022.

medical clearance for emergency shelter placement for veterans during nights, weekends, and holidays; and program staff would follow up with the veterans the next workday.

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).[68]

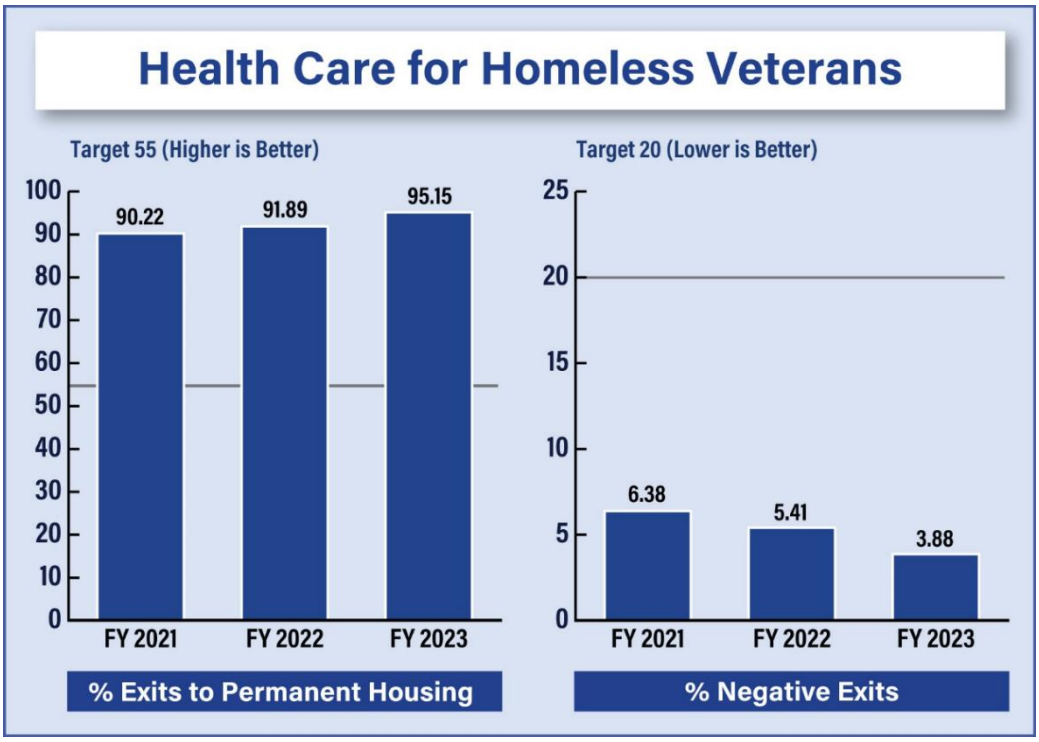


Figure 14. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The OIG found the facility's HCHV program met performance measure targets for HCHV1 and HCHV2 for FYs 2021 through 2023. In an interview, program staff attributed meeting these targets to veterans' motivation to transition out of the shelters into permanent housing. Staff explained that they offered veterans shelter placement when they entered the program, then completed an initial mental health assessment to ensure they receive needed services. In response to an OIG-administered questionnaire, the Homeless Program Coordinator indicated staff monitored lengths of stay in VA contracted shelters, tracked completed initial mental health

[68] 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*.

assessments and referrals, and documented employment status or source of income. The staff added they used the collected information to improve the program. Staff reported knowing they were doing good work when they encountered veterans who were formerly homeless but now full-time VA employees, self-sufficient, and in permanent housing.

Program staff described two barriers homeless veterans face: limited transportation and the lack of affordable housing. While Poplar Bluff, Cape Girardeau, and Farmington had limited public transit systems, other areas had no public transportation. Further, veterans often have no or low income and struggle to meet rent requirements. Therefore, program staff work with veterans to arrange transportation and help them apply for VA and non-VA benefits.

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 OIG found the facility did not meet the performance measure target for FY 2023.[72] The Veterans Justice Outreach Specialist reported that barriers to meeting this target included limited access to jails and having to schedule appointments in advance with incarcerated veterans. As a result, the specialist reported focusing enrollment efforts on working with veterans referred to treatment courts.

In an interview, the Veterans Justice Outreach Specialist described providing services to veterans through the Southeast

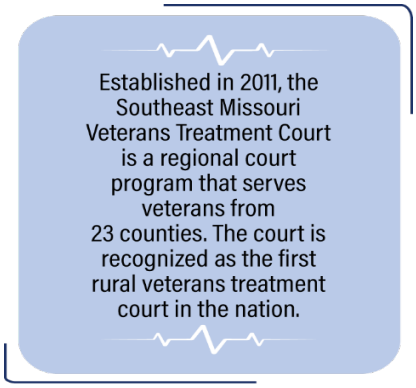


Figure 175. *Southeast Missouri Veterans Treatment Court. Source: OIG analysis of documents and interviews.*

[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 FY 2023, the facility's target was 38 veterans entering the Veterans Justice Program; however, the facility only reached 71.05 percent of their target. VHA Homeless Program Office, *Technical Manual: FY 2023 Homeless Performance Measures.*

Missouri Veterans Treatment Court.[73] The specialist reported receiving referrals from the court administrator, attorneys, probation officers, and facility staff. After receiving referrals, the specialist meets with the veterans in the county where they live or were incarcerated, completes a court intake screening and program entry assessment, determines the veterans' initial needs, and refers them for VA services. The specialist coordinates services until veterans either complete treatment court or need no further services. In an OIG-administered questionnaire, the specialist indicated the objectives of participating in the veterans treatment court are to reduce repeat offenses, facilitate treatment for mental health and substance use disorders, and enhance veterans' overall health and well-being.

Meeting Veteran Needs

The OIG reviewed program documentation and noted the Veterans Justice Outreach Specialist conducted over 70 community and educational events from FYs 2021 through 2023, including presentations to court professionals on regional veterans treatment courts in rural settings. The specialist served as an instructor for local law enforcement and presented on topics like VA resources and crisis intervention skills, attended county council meetings, and participated in monthly meetings with homeless program staff.

The specialist identified stable housing and transportation as barriers to meeting program goals. The specialist referred veterans living in temporary housing to the HCHV program for assistance with finding permanent housing and other services. The specialist also worked with community partners to assist with transportation for veterans participating in the veterans treatment court, who must attend weekly court sessions but had limited transportation options.

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."[74] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by

[73] The specialist reported that veterans justice program specialists from the VA St. Louis Healthcare System provided outreach services to the prison located within the facility's service area. "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, *Veterans Justice Programs*, April 4, 2024.

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

individualized services, including healthcare and employment assistance, necessary to maintain housing.[75]

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).[76] The OIG found the program did not meet the performance measure target for FYs 2021 through 2023.[77] In an interview, the Homeless Program Supervisor reported the program had 150 allotted vouchers through three public housing agencies across 28 rural counties.[78] Program leaders identified the lack of affordable housing and limited transportation options as barriers to veterans using housing vouchers.

In addition, leaders stated staff turnover, vacancies, and recruitment issues were challenges to serving veterans. They indicated that the large geographic service area, combined with the complex needs of homeless veterans and high caseloads, may have contributed to staff burnout and turnover. In response to these challenges, leaders developed an action plan that included identifying new landlords to increase housing options for veterans and ensuring equitable assignments for staff.

The Homeless Program Supervisor stated the program's Outreach Coordinator conducts outreach with veterans and community partners, and the Coordinated Entry Specialist is the point of contact for program referrals and assists veterans in completing the intake assessment, confirming eligibility, and obtaining documents needed by the housing authority. In response to an OIG-administered questionnaire, the supervisor noted staff tracked outreach and engagement efforts and shared the information during monthly staff meetings.

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

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

[77] The facility's HMLS3 scores were 88.89 percent for FY 2021, 81.33 percent for FY 2022, and 77.33 percent for FY 2023.

[78] The program serves veterans in 23 counties in Missouri and 5 counties in Arkansas.

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 did not meet the target for FYs 2022 and 2023.[80] The Homeless Program Supervisor said the program had not met the target since FY 2018. The supervisor recently asked staff to review current employment information with each veteran and update the national homeless database. The database now showed the program meeting the target, according to documentation the VISN 15 Network Homeless Coordinator provided to the facility.

The Homeless Program Coordinator reported program challenges when veterans have no or low income but must pay rent. The coordinator stated program staff encourage veterans to apply for VA benefits, and the Homeless Program Supervisor stated the Outreach Coordinator was certified to help veterans apply for social security benefits.

Homeless program staff reported that community partners are essential to veterans' success in accepting shelter placement and obtaining permanent housing. The Animal Welfare Alliance is an organization that reduced barriers for veterans with pets. Veterans' dogs were not allowed to reside in the shelter because they were not registered as service animals. The Animal Welfare Alliance provided shelter, vaccines, and food to the veterans' dogs for up to 90 days and ensured the dogs were not adopted or euthanized while in their care.

Figure 16. *Temporary services for veterans' pets.*
Source: OIG interviews.

Program staff explained that community partners were essential to veterans' success in maintaining permanent housing because they provided clothing vouchers and assisted with security deposits, household items, past due rent, and furniture delivery.

Conclusion

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

[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] The facility's VASH3 scores were 44.44 percent for FY 2022 and 31.58 percent for FY 2023.

Summary of Findings and Recommendations

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

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

Critical

Finding: The facility experienced frequent turnover in key leadership positions.

Recommendation 1: The OIG recommends the Veterans Integrated Service Network Director takes actions to ensure stable and consistent leadership at the facility.

Finding: Managing union grievances was time consuming for leaders.

Recommendation 2: The OIG also recommends Veterans Integrated Service Network leaders assist facility leaders to improve interactions with local union leaders.

Major

Finding: The facility had 10 security cameras that were nonoperational at the time of the OIG site visit.

Recommendation 3: The OIG recommends the Interim Medical Center Director ensures all security cameras are operational.

Finding: The facility had staffing shortages across the primary care teams and severe shortages for primary care social workers.

Recommendation 4: The OIG recommends the Interim Medical Center Director ensures primary care teams are staffed according to Veterans Health Administration guidelines.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs.[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 June 24 through 27, 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, 2022, through September 30, 2023.

[2] The OIG sent a questionnaire to three VSOs: Disabled American Veterans, Veterans of Foreign Wars, and American Legion.

[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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Table B.2. Health of the Veteran Population*

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

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

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 10, 2024

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Facility Inspection of the VA Poplar Bluff Health Care System in Missouri

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

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

1. Attached is the facilities response to the VA OIG DRAFT REPORT - Healthcare Facility Inspection of the VA Poplar Bluff Health Care System.
2. I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

Patricia L. Hall, PhD, FACHE
Network Director
VA Heartland Network (VISN 15)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 12, 2024

From: Director, VA Poplar Bluff Health Care System (657/A4)

Subj: Healthcare Facility Inspection of the VA Poplar Bluff Health Care System in Missouri

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review the VA Office of Inspector General's Comprehensive Healthcare Inspection Program report of the John J. Pershing Veterans Affairs Medical Center. I concur with the assessment and findings and appreciate the review team's thoroughness and dedication to quality improvement across the VA.
2. A corrective action plan remedying identified deficiencies is provided. The John J. Pershing Veterans Affairs Medical Center will continue to monitor performance to ensure all recommendations are addressed and action plans successfully implemented.

(Original signed by:)

Fabian T. Grabski
Interim Medical Center Director

Appendix E: VA Responses

Recommendation 1

The OIG recommends the Veterans Integrated Service Network Director takes actions to ensure stable and consistent leadership at the facility.

__X__Concur in principle

_____Nonconcur

Target date for completion: Completed

VISN Director Comments

The reasons for leadership attritions were considered. Prior facility leadership vacancies were created due to positive attrition causes. The Poplar Bluff leaders sought positions that were promotions or closer to family at a desired location. During the transition period, the VISN 15 Executive Leaders have actively posted positions and requested long term details to fill the vacancies. A permanent Director has been selected and is pending final approval. Additionally, the Associate Director position has been permanently filled and is active in the role. The Chief of Staff has been in his role for 3 years and would be considered stable and consistent leadership. The VISN 15 Executive Leadership remains committed to supporting any senior leadership role transitions.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The OIG recommends Veterans Integrated Service Network leaders assist facility leaders to improve interactions with local union leaders.

__X__Concur in principle

_____Nonconcur

Target date for completion: Completed

VISN Director Comments

The reasons for increased time requirements for managing union grievances were considered. Poplar Bluff has a very engaged and active union. The VISN 15 Executive Leaders continue to engage all union partners by meeting with the aggregate facility unions during a Labor Management Forum on a regular basis to enhance communication and consensus. While

VISN 15 Human Resource support is provided at the VISN level, it is the facility leadership that is responsible for reconciling any local grievances or conflict. The VISN 15 Executive Leadership is always available for consultation or to answer questions that may arise from facility leaders when managing union grievances. The process to participate in filing grievances by the union continues to be honored and respected by the VISN 15 Executive Leadership.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The OIG recommends the Interim Medical Center Director ensure all security cameras are operational.

__X__Concur

_____Nonconcur

Target date for completion: June 30, 2025

Director Comments

Police Services Chief has completed a review of functionality of the security cameras and relayed this to the Medical Center Director for review. A plan for correction of the security cameras will be established. Compliance with operation of security cameras will be reviewed by the Police Services Chief who will review operation of 20% of all security cameras monthly to evaluate function. Audits will be reported to the Executive Leadership Board on a monthly basis. Numerator: Number of cameras which were evaluated and functioning properly, Denominator: Number of cameras which were evaluated. Audits will continue until target compliance of 90% of cameras operational for two quarters.

Recommendation 4

The OIG recommends the Interim Medical Center Director ensures primary care teams are staffed according to Veterans Health Administration guidelines.

__X__Concur

_____Nonconcur

Target date for completion: March 31, 2025

Director Comments

The facility will complete a review of the current staffing ratio of Social Workers in primary care clinic. A comparison of three facilities that are level 3 nationwide to evaluate social worker

staffing ratios in comparison with the suggested discipline specific staffing ratios according to VHA Handbook 1101.10(2). The facility Associate Chief of Staff for Primary Care and ADPCS will make a recommendation related to facility specific needs for Social Worker staffing for primary care clinics. Once the established facility specific staffing ratio is determined the Associate Chief of Staff for Primary Care and ADPCS will evaluate compliance with the recommended Social Worker staffing level. This will be reported to the Clinical Practice Council monthly until 90% of staffing target has been achieved for two monthly reporting periods. Numerator: Number of social workers assigned to primary care clinics. Denominator: Number of social workers recommended per the facility specific guidance for primary care teams.

OIG Contact and Staff Acknowledgments

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

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 15: VA Heartland Network
Director, VA Poplar Bluff Health Care System (657)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  Arkansas: John Boozman, Tom Cotton
  Missouri: Josh Hawley, Eric Schmitt
US House of Representatives
  Arkansas: Rick Crawford
  Missouri: Eric Burlison, Bob Onder, Jason Smith

OIG reports are available at www.vaoig.gov.