US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Salem Healthcare System in Virginia

Healthcare Facility Inspection	24-00549-56	February 12, 2025

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. 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 Salem Healthcare System (facility) from March 26 through 28, 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, and both employees' and veterans' experiences. In interviews with the OIG, leaders identified unique aspects of the organization, such as lack of broadband internet coverage that limits telehealth options, a 90-year-old building, and the rural location with a small medical community, as well as the system shock of the COVID-19 pandemic, as factors that affected staffing levels and veterans' care over the past several years. To minimize the impact of these challenges, facility leaders implemented changes like employing recruiters to increase hiring of nurses and providers and developing a mobile health team to provide veterans' care in remote locations.

Leaders spoke to their efforts to improve communication with facility staff. Some of these efforts included conducting town hall meetings at different intervals throughout the day to allow more staff to participate. These town halls were recorded and posted to the facility's SharePoint site for staff to review. Leaders also described visiting work areas to talk about issues and answer questions from staff. Leaders said employees experienced burnout at the end of the pandemic, so

[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.

they implemented relaxation rooms for employees to use, when needed, and had psychologists visit work areas to offer support.

Leaders effectively communicated with patient advocates and veterans service organizations to address veterans' concerns and meet their care needs.[2] The Director shared an example of when a veterans service organization representative raised concerns about a veteran's care at a non-VA hospital; they transferred the veteran to the facility, where providers then completed a thorough exam.

Environment of Care

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

The OIG found that overall, the facility was clean and welcoming, with accommodations such as shuttle service and valet parking. The OIG learned that some restrooms near the main entrance had ongoing repair issues. The repairs were completed on one of the restrooms during the site visit, while repairs of the other restroom remained ongoing. The OIG also observed ceiling leaks in some areas, which leaders said they had a contract for repairs. Additionally, the Emergency Department had ongoing construction projects since 2019 that were restricting the space available to care for veterans. The OIG recommends the Executive Director address the construction issue affecting veterans' care.

The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act expanded VA health care to veterans exposed to toxic substances.[3] The OIG reviewed toxic exposure screening processes and veterans' wait times for screening and learned that staff educate veterans on available healthcare services through outreach events, and veterans can walk into the clinic for an initial screening with an average wait time of 15 minutes. However, the OIG found the toxic exposure screening navigators did not review VA screening data for accuracy. For instance, VA data indicated staff had not completed 815 secondary screenings for veterans with a positive initial screening, but a navigator said the data were incorrect. The OIG performed a limited review of the information; confirmed there were data

[2] Patient advocates are employees who help resolve veterans' concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.Veteran service organizations are non-VA, non-profit groups that educate veterans and their families about VA benefits. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

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

errors, like duplicate entries; and recommended the navigators verify the data and address any backlog for veterans waiting for secondary screenings.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found leaders had not updated the facility policy on the communication of test results to align with VHA's national directive.[4] However, leaders completed the new policy in September 2024.

Through interviews, the OIG learned that quality management staff and leaders supported process improvement projects to improve communication of abnormal test results. For instance, quality management staff audit electronic health records to determine whether ordering providers were notified of abnormal test results, and primary care staff audit records to determine whether the providers notified the patients. The OIG did not identify any open OIG recommendations nor barriers to long-term improvements related to general patient safety.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the PACT Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

The facility had several vacancies among providers, nurses, and administrative staff. However, the OIG found that leaders actively addressed these deficiencies through recruitment and retention efforts. Primary care team members shared concerns related to overall workload demand and efficiency; however, leaders indicated they were aware of these concerns and addressing them.

Primary care leaders shared an example of an improvement project to improve patients' access to care. They established a clinic with providers dedicated to new patients, while providers in other clinics focused on the established patients who need follow-up care. The new clinic helped reduce overall appointment wait times to less than 20 days.

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

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. Program staff assist homeless veterans in accessing VA healthcare services and benefits. They also work with multiple community partners to help them find housing and employment. Staff identified lack of affordable housing as a barrier and hired a housing specialist to engage with landlords to increase options.

What the OIG Recommended

The OIG made two recommendations relating to the environment of care:

1. The Executive Director mitigates the impact of construction on patient care in the Emergency Department.
2. The Chief of Staff ensures the toxic exposure screening navigators verify data to track veterans waiting for secondary screenings and address any backlog.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors agreed with the inspection findings and recommendations and provided acceptable action plans (see appendixes D and E, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 Salem Healthcare System
Salem, Virginia
Level 1c-High Complexity
Salem County
Hospital Referral Region: Roanoke

Description of Community

POPULATION

Female **527,544**	Male **509,636**
Veteran Female **6,747**	Veteran Male **65,664**

Homeless - State **6,529**
Homeless Veteran -State **392**

MEDIAN INCOME

$49,922

EDUCATION

88% Completed High School
56% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **144**

SUBSTANCE USE

28.9% Driving Deaths Involving Alcohol
17.4% Excessive Drinking
431 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	367,506
Carpool	33,565
Work at Home	23,622
Walk to Work	10,523
Other Means	5,502
Public Transportation	3,701

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**35.5 Minutes, 30 Miles**
Specialty Care	**56.5 Minutes, 53 Miles**
Tertiary Care	**164.5 Minutes, 171 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **10,098**

Veterans Receiving Teleheath (VHA)	41%
Veterans Receiving Telehealth (Facility)	32%
<65 without Health Insurance	12%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

10,281

134 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.15 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
17	28

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	36K
Unique Patients VA Care	34K
Unique Patients Non-VA Care	19K

COMMUNITY CARE COSTS

Unique Patient	$32,072
Outpatient Visit	$387
Line Item	$1,150
Bed Day of Care	$353

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.69%
Facility Total Loss Rate	12.89%
Facility Retire Rate	3.80%
Facility Quit Rate	8.67%
Facility Termination Rate	0.36%

★ VA MEDICAL CENTER

VETERAN POPULATION

0 — 75,438

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 the Healthcare Facility Inspection (HFI) cyclical review program 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

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

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

High Reliability Organization Framework

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

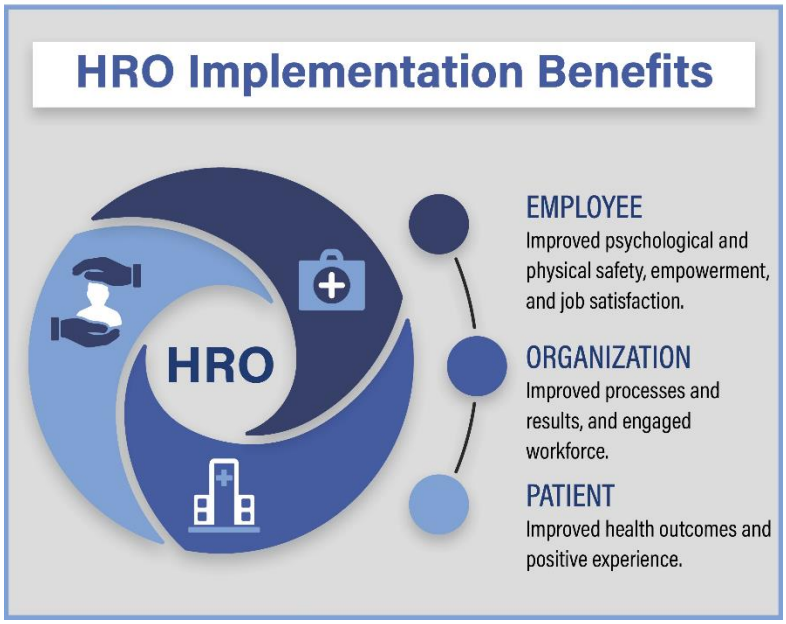

Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, 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/FAQ_Home.aspx. (This web page is not publicly accessible.)

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

PACT Act

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

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

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

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

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

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

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

Content Domains

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

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

The VA Salem Healthcare System (facility), which opened in 1934, has the only VA medical facility to be dedicated by a sitting US president (Franklin D. Roosevelt). According to the Chief, Quality Management, at the time of the inspection, the facility's executive leaders included an Executive Director (Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), acting Associate Director, and acting Assistant Director. The Associate Director retired in February 2024. The Assistant Director was named the acting Associate Director, and the Assistant Chief, Fiscal was the acting Assistant Director. The Director, assigned in October 2016, was the most tenured senior leader in the system. In fiscal year (FY) 2023, the facility's budget was approximately $570 million. The facility had 146 operating beds, which included 79 hospital, 30 community living center, and 37 domiciliary beds.[13]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/homeless/dchv.asp.

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

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

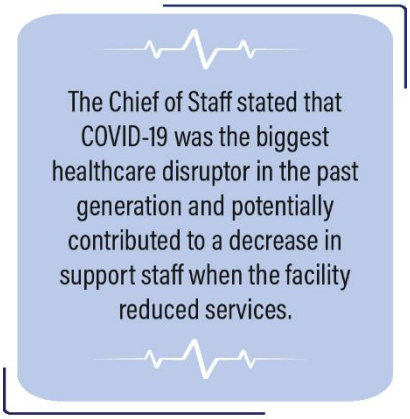

Figure 4. *Facility systems shocks. Source: OIG interview.*

Staff responses to the OIG questionnaire identified turnover in key leader positions, significant changes to services offered, and other significant events like the COVID-19 pandemic as system shocks. Leaders described the age and location of the facility as unique aspects that affect the organization. The United States Veterans Administration Hospital, now VA Salem Healthcare System, was dedicated on October 19, 1934. The Director pointed out the challenges of delivering health care with 90-year-old infrastructure. The historic buildings contain asbestos and lead that contractors must abate during renovations, which increases expenses and limits who is qualified to perform the work.

According to facility leaders, the healthcare system's extremely rural location and small medical community means the facility competes with other facilities for medical personnel. Many support staff did not return after the pandemic, resulting in multiple vacancies that supervisors then filled, usually, by less experienced staff. The ADPCS reported that some nurses left the profession altogether during the pandemic, and others left for nursing opportunities with higher pay. The Chief of Staff added that some providers left to work in non-VA alternative health care positions, such as online mental health care, and have not returned.

Additionally, the area's mountainous landscape can cause difficulties for patients and staff traveling to the facility. There are also problems with local broadband internet capabilities in the service area that limit the facility's ability to offer telehealth. Therefore, the Director described

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

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

developing a mobile health program in which nurses travel to remote locations closer to veterans' homes to take vital signs, answer questions, and facilitate care.

According to leaders, the facility faced another challenge with the release of the *VA Recommendations to the Asset and Infrastructure Review Commission* report in March 2022, which led members of the community to believe the facility would close and stop applying for positions.[19] Leaders communicated that the facility was not closing and hired a nurse recruiter in March 2023 to help fill vacancies. At the time of the OIG site visit, the nursing vacancy rate was 12.10 percent, down from 23.32 percent a year before.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23]

The OIG also reviewed responses to its questionnaire in which most staff members agreed that leaders had made changes to communication. However, most were neutral about whether the changes were an improvement. In interviews, leaders identified several strategies to improve

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

[19] The Asset and Infrastructure Review Commission was a VA initiative to study the current and future healthcare needs of the veteran population, as well as healthcare facility infrastructure. This report included a recommendation to construct a replacement for the VA Salem Healthcare System facility with an inpatient mental health unit, residential treatment programs, a community living center, and outpatient services, and facility staff should refer patients to community resources for medical-surgical, emergency, and specialty care services. "VA Recommendations to the AIR Commission," Department of Veterans Affairs, updated March 14, 2022, accessed April 26, 2024, https://www.va.gov/AIRCOMMISSIONREPORT/index.asp.

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

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

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

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

communication with frontline staff, including monthly town halls at three different times to enable more staff to participate. The town halls included information about the facility's work toward becoming an HRO, data from patient safety reports, and updates on ongoing projects. The OIG noted the town hall slides were posted to the facility SharePoint site for staff to review.

Leaders also described visiting work areas to increase communication with staff. The ADPCS explained they conducted both scheduled and unscheduled visits. The Director and ADPCS shared that they believe staff feel comfortable approaching leaders during the visits to talk about issues and ask questions.

The Director stated the facility SharePoint site had links for users to "Ask the Director," "Submit a Kudos," and "Submit a Great Catch," which allowed staff to ask questions, recognize other staff for something positive, or share relevant information with leaders and other staff. When staff submitted a question, the Director posted both the question and answer on the site, as well as shared them (along with kudos and great catches) during town halls.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[24] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[25] 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.

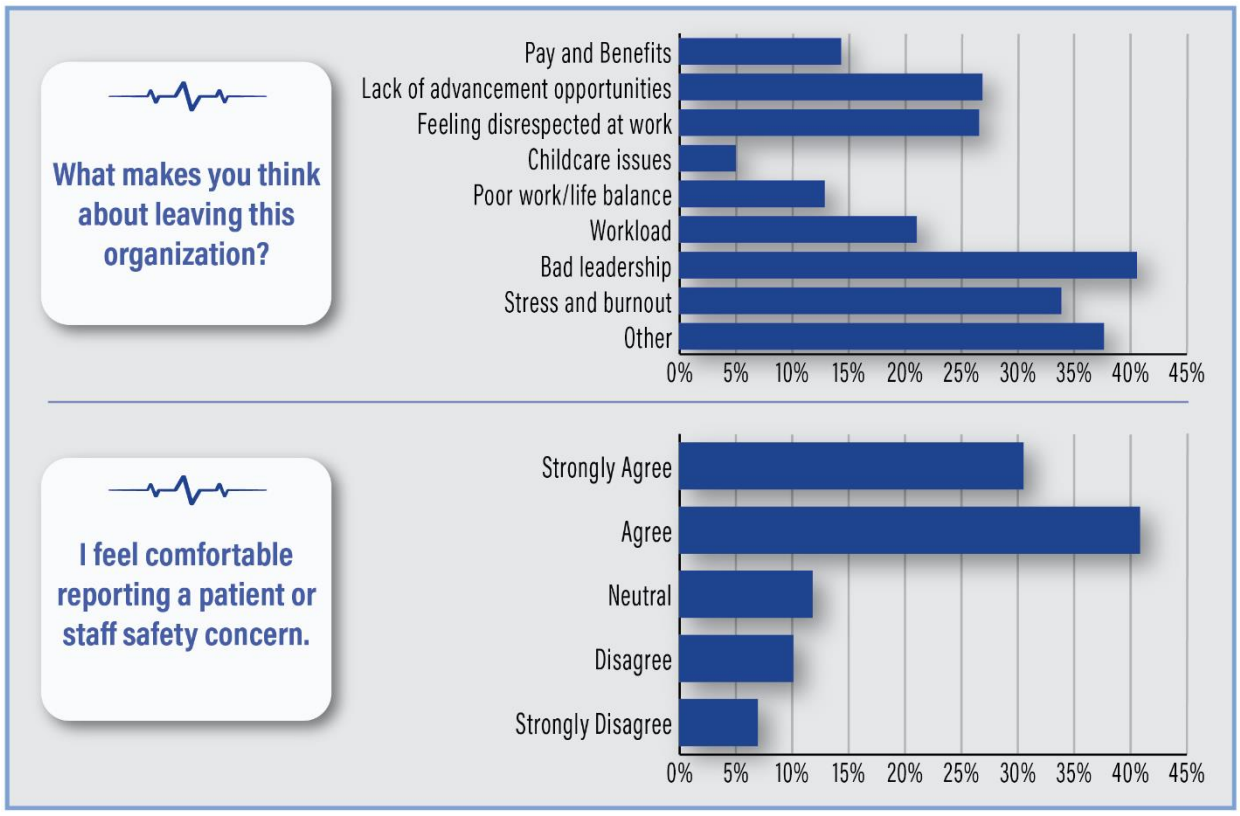

Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

The Director stated employees experienced burnout at the end of FY 2022, adding that the pandemic contributed to negativity in the workplace. To respond, the Director highlighted executive leaders' focus on the VA mission and employee health, and to celebrate things that are going well. For example, leaders set up employee relaxation rooms, psychologists visit work areas to talk with employees and support anyone feeling stressed, and the Director includes

[24] 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.

[25] 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.

positive happenings around the facility in the monthly town halls and sends kudo messages to employees.

OIG questionnaire data indicated that some employees had concerns about leaders. Just over 40 percent of respondents listed leadership challenges as a reason for considering leaving the facility. The Chief of Staff stated the area where leaders had the most work to do was in convincing employees that leaders were working on their behalf. The Director and ADPCS discussed vacancies in frontline supervisor and nurse manager positions as being disruptive for employees; however, leaders had filled several of these vacancies at the time of the OIG site visit.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.[26] Responses to the OIG questionnaire indicated most employees felt comfortable reporting patient and safety concerns. The Director conveyed that the facility had been on an HRO journey for three years and closed every major committee meeting by asking attendees to identify any patient, safety, or ethical concerns they would like to discuss. The OIG encourages the executive leaders to continue their efforts to improve employee experiences.

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.[27] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[28] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

OIG questionnaire responses indicated leaders were responsive to veterans' concerns. The Director said patient advocates provided feedback to the leaders that staff closely involved with the issue should be more engaged in addressing it, and leaders implemented this change the month before the OIG site visit. The Director reported meeting with VSOs at least monthly, as well as receiving emails and telephone calls from VSO representatives regarding veterans' issues. During an interview, the Chief of Staff said that, due to the close-knit community, VSO representatives often contact facility staff about concerns of their veteran friends or colleagues. The Chief of Staff added that veterans also feel comfortable contacting leaders directly, without working through a VSO.

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[26] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout."

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

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

The Director shared an instance when a VSO representative raised concerns about the care a veteran received at a community hospital. The Director worked with the hospital staff to transfer the veteran to the facility, where providers then completed a thorough exam and detected a potentially terminal illness at an early stage.

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

Figure 7. *Facility photo.*
Source: "Salem VA Medical Center," Department of Veterans Affairs, accessed July 9, 2024, https://www.va.gov/salem-health-care/locations.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[30] 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.[31]

[29] VHA Directive 1608(1).

[30] 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.

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

Transit and Parking

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

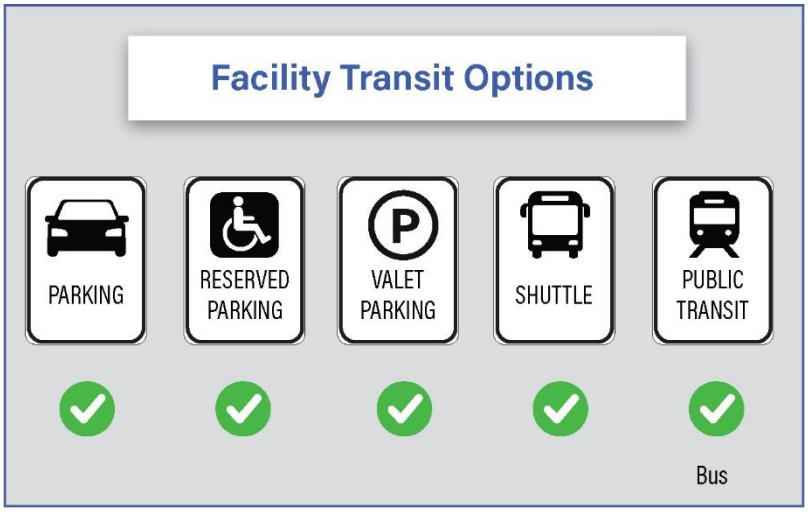

Figure 8. *Transit options for arriving at the facility.*
Source: OIG observations and analysis of documents.

The OIG used both Google and Apple navigation to reach the facility and found both to be accurate. There was no map on the facility's website. Signs directed veterans to the Emergency Department and main entrance. In parking lots B and C, used for the main entrance, the OIG determined there were ample parking spaces, including spots accessible for those with disabilities. The facility also had valet parking and shuttle service with numerous stops throughout the campus.

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.[32]

The OIG found the main entrance welcoming and clean, with natural light from a glass roof in the lobby area. The entrance had wheelchairs available, and volunteer greeters used them to assist veterans to their appointments. The OIG also observed a group of veterans gathering to socialize at a coffee shop in the lobby.

Figure 9. *Facility main lobby by the front entrance.*
Source: Photo taken by OIG inspector.

However, the OIG noted ongoing repairs to the restrooms near the main entrance, which the Patient Advocate's Office had received complaints about, according to their reports. Facility staff attributed maintenance problems to the

[32] 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*.

advanced age of the buildings and challenges in hiring qualified workers due to competition from higher salaried positions in the private sector. Staff repaired one of the restrooms while the OIG was on-site, but the repairs to the other one remained incomplete.

The Associate Director explained the expansion of the Emergency Department had been underway since 2019. According to the Associate Director and the Chief Engineer, construction mistakes had led to repeated work delays, and neither could say when the project would be finished. The construction areas were marked and separated from veterans walking into the facility and did not seem to create problems with navigation. However, the Emergency Department Manager and Assistant Manager told the OIG the project had negatively affected their ability to care for veterans due to lack of space. The Assistant Manager provided Emergency Department diversion and overcrowding statistics that supported this assertion.[33] The OIG recommends the Executive Director mitigate the impact of construction on patient care in the Emergency Department.

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.[34]

At each intersection and in the main lobby, the OIG noted maps on the wall showing the current location with a legend by department. The maps also included scannable codes that open a cell phone application to help with navigation. Additionally, the facility had navigation stations where veterans could print maps with directions (see appendix C, figure C.1). The OIG found two maps with scannable codes that led to an application showing numbered buildings only, without the departments listed. Veterans who knew only the department, but not the building number, would have difficulty using the application. However, the other map codes that included departments worked well.

The Associate Director outlined a navigation project, in conjunction with a painting project, that will organize the facility into three areas and brand them with distinctive symbols (see appendix C, figure C.2). Facility leaders plan to include these symbols on the signs throughout the area to allow veterans to identify their location at a glance.

[33] Diversion occurs when an emergency department cannot safely care for additional patients. "What You Need To Know About ER Diversion," Health Action Council, June 28, 2021, accessed April 12, 2024, https://healthactioncouncil.org/resources/blog/what-you-need-to-know-about-er-diversion/.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The volunteer greeters and information desk staff stated they were not formally trained to assist veterans with sensory impairments; however, they were available to help any veteran navigate the facility as needed. On each trip through the main entrance, the OIG observed information desk staff interacting with and assisting veterans.

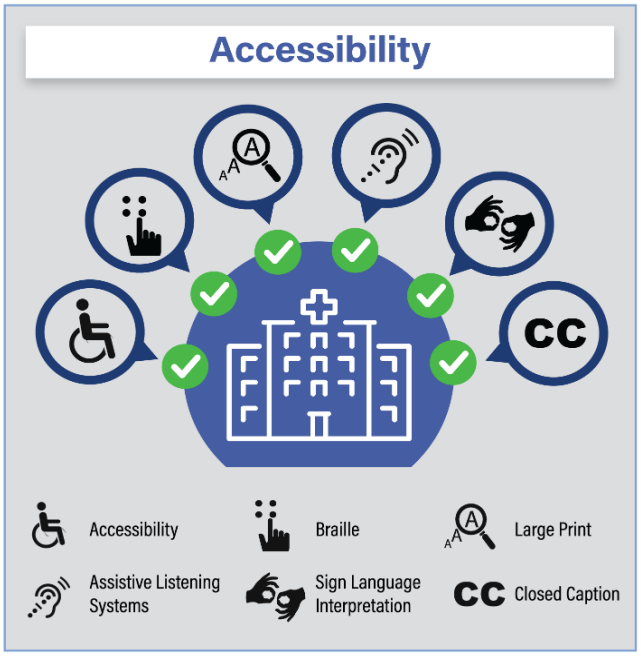

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

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.[36]

The OIG was able to locate the clinic where staff perform initial toxic exposure screenings with directions provided by information desk staff. Clinic staff stated the walk-in wait time was 15 minutes, which was the average on most days. There was also information about VA services, and staff to assist veterans with benefits and enrollment in a separate building. During interviews, the toxic exposure screening navigators said they completed several outreach events to inform veterans of available services and scheduled an upcoming event for June 2024.

At the time of the OIG inspection, VA statistical data showed staff had not completed secondary screenings for 815 veterans with a positive initial screening.[37] One of the navigators said the

[35] 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.

[36] 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.

[37] Medical providers perform the secondary screenings; they enter veterans' diagnoses into their electronic health records, enter consults for follow-up care, and serve as points of contact for veterans who need assistance to resolve concerns. Department of Veterans Affairs, *Toxic Exposure Screening Navigator Roles, Responsibilities, and Resources*, April 2023.

number of incomplete secondary screenings was inaccurate. The OIG performed a limited initial review of the information used for the VA statistical data and found duplicate entries for a single veteran and apparent erroneous records. The navigators did not have a process for reviewing the statistical data for accuracy and were unable to determine whether screenings had been completed. The OIG recommends the Chief of Staff ensures toxic exposure screening navigators verify data to track veterans waiting for secondary screenings and address any backlog.

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.[38] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues. The OIG did not identify repeat issues.

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 found the facility to be generally clean; equipment maintenance stickers were up to date; supply rooms were clean and did not contain outdated supplies; and food storage areas were generally clean. However, the OIG observed ceiling leaks in the corridors of buildings 2 and 42. Facility leaders stated they needed to turn off the heat before they could fix the leaks, so they initiated a contract for the project to begin in the summer of 2024; therefore, the OIG made no recommendations.

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

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

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.[39] 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.[40] 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's policy for addressing the communication of test results focused on critical results and provider notification but did not include processes to address urgent, noncritical results and patient notification. Leaders had not updated the facility policy to reflect VHA's national requirements for providers to notify patients within seven days of receiving test results that need action, such as orders for additional medication or diagnostic tests, and to include written workflows that describe the team members' role in the communication process. Leaders said the Medical Executive Board led a workgroup that met weekly to develop a new policy to align with the national requirements. Leaders had a projected completion date of June 2024, but did not complete it until September 2024.

Action Plan Implementation and Sustainability

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

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[41] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG did not find any open recommendations from the previous two years. During an interview, the OIG learned the executive leadership team and quality management staff met twice weekly to review reported patient safety events, assess trends, and communicate with

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

[40] 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.

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

relevant department leaders. Through review of recommendations and interviews, 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.[42] 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.[43] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality management staff said they maintain a process to identify opportunities to improve communication of abnormal test results as part of continuous learning. The process includes staff auditing electronic health records, focusing on communication of abnormal test results to the ordering provider, and submitting reports to the Medical Records Committee. Primary care staff also audit electronic health records to determine whether providers acknowledged test results and communicated them to the patients.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[44] 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.[45] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

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

[43] VHA Directive 1050.01(1).

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

[45] 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).

staffing shortages.[46] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG found the facility had several vacancies in core primary care team roles, including three medical providers, three nurses, and two medical support assistants. In addition, the chief of primary care position was vacant at the time of the OIG site visit. The ADPCS stated that recruiting licensed practical nurses and registered nurses had been difficult since the pandemic due to competition from travel nursing opportunities and higher pay in the private sector.

Despite the vacancies, facility leaders said they addressed some staffing challenges through increased recruitment. The Chief of Staff stated that more candidates had applied and accepted positions over the prior twelve months after leaders hired a provider recruiter, who was able to leverage professional networks to identify candidates for positions that were traditionally difficult to fill. A new nurse recruiter had established relationships in the community, including at local colleges, and participated in hiring fairs and events; these efforts increased the number of applicants and resulted in the timely hiring of more qualified candidates. Additionally, the acting Chief of Access and Scheduling shared that leaders implemented the Hire Right, Hire Fast model, along with a special salary rate, to improve recruitment and retention of medical support assistants.[47] The Chief of Staff and ADPCS reported also offering recruitment and retention incentives, such as performance pay for providers and special salary rates for nursing staff.[48]

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.[49] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[50]

Primary care leaders acknowledged providers expressed frustration with growing panel sizes and workload demands. Primary care team members told the OIG that generally, panel size and coverage expectations were not reasonable, due to the administrative burden of completing

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

[47] "Hire Right, Hire Fast…is a best practice recruitment and hiring model…applied nationwide to Medical Support Assistants and Housekeeping Aides." Department of Veterans Affairs, *Annual Report on the Steps Taken to Achieve Full Staffing Capacity*, May 2021.

[48] "Performance pay is intended to recognize the degree to which an individual physician, dentist, or podiatrist achieves specific goals and performance objectives prescribed on a fiscal year basis by an appropriate management official." "The amount is determined solely at the discretion of the approving official based on the achievement of the specified goals and objectives and is paid annually as a lump sum." VA Handbook 5007/59, *Pay Administration*, October 2, 2020.

[49] "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).

[50] VHA Directive 1406(1).

specialty care consults and responding to view alerts (notifications in electronic health records), secure messages from veterans, and clinical reminders (alerts that veterans are due for preventive health services).[51] These issues also negatively affected workflow efficiency. Primary care leaders stated they were aware of team members' concerns about workload and efficiency and were addressing the challenges. Leaders shared an example in which they coordinated with the facility's informatics team to streamline the nephrology consult and documentation process and modify the nephrology consult template, so it is easier and quicker for providers to complete.[52]

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[53] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care leaders discussed several process improvement projects in FY 2023, including establishing a panel management workgroup to increase patient access to care and reduce overall appointment wait times. Workgroup staff reviewed provider panels to optimize scheduling and contacted patients to offer earlier appointments when available. Primary care leaders also set up and staffed a clinic for new patients at the Salem facility. Primary care providers explained that providers in the new clinic will see the new patients, and other providers will focus on the established patients who need follow-up care. The new clinic had helped reduce appointment wait times to less than 20 days.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found veteran enrollment at the facility decreased since FY 2021. However, primary care and facility leaders said they reviewed provider panels in anticipation of projected increases in newly eligible veterans and determined current capacity was sufficient to absorb any additional enrollees. Primary care leaders continue to monitor enrollment and patient population data to determine future staffing needs.

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[51] A view alert is an electronic notification in a computerized patient record system designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, Office of Information and Technology (OIT), *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, December 2023. Preventive services may include cancer screening, immunizations, and health education. VHA Handbook 1101.10(2).

[52] Nephrology is "a branch of medicine concerned with the kidneys." *Merriam-Webster*, "Nephrology," accessed December 11, 2024, https://www.merriam-webster.com/dictionary/nephrology.

[53] VHA Handbook 1101.10(2).

Primary care providers told the OIG the toxic exposure screening added up to 10 minutes to visits, not including the additional time nurses or social workers took during the appointments to answer veterans' questions and provide support and benefit resources. Additionally, if veterans screen positive for a toxic exposure, providers may have to enter consults for additional services, which can further prolong the appointment time and disrupt the daily workflow. Primary care leaders reported being aware of these concerns and clarifying roles and responsibilities with providers.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[54]

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).[55] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[56]

Program staff reported using the point-in-time count to trend the number of homeless veterans in the facility's service area to measure the program's effectiveness. Staff also said the homeless program's large, rural service area, including parts of the Appalachian Mountains, as well as

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

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

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

some veterans' mistrust of government agencies and unwillingness to identify as homeless posed challenges for them to identify and provide resources for veterans.

The facility's combined homeless program team (HCHV, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs) had 12 members at the time of the OIG site visit. Staff conduct outreach, often in conjunction with scheduled off-site meetings, and rely on community partners to identify veterans to enroll in the homeless program. For example, the Coordinated Entry Specialist attended By Name List meetings to identify homeless veterans, and then staff visited homeless shelters when attending meetings in the same area.[57]

Program staff also identified homeless veterans through facility services. For instance, facility staff notified the program staff about homeless veterans who presented to appointments at the main facility or a community-based outpatient clinic. Program staff also ran a walk-in homeless clinic at the main facility and responded to calls from the national homeless hotline to put veterans in contact with staff at their local facility. Additionally, program staff had access to the Homeless Management Information System, a database used by nonprofit and community agencies to track homeless individuals. Leaders paid the annual fee for database membership out of the facility's general funds. The Coordinated Entry Specialist used the system to cross-reference veterans already enrolled in the program and identify other local veterans for outreach.

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).[58] The facility did not meet the HCHV1 or HCHV2 targets for FYs 2021 and 2022 but met both targets for the first quarter of FY 2023. Program staff told the OIG that barriers to meeting the HCHV1 target included temporary placement of homeless veterans with COVID-19 in hotels, which did not constitute permanent housing. A challenge to meeting the HCHV2 target was miscommunication between staff and veterans about whether guidelines allowed veterans to enter the contracted residential facility while under the influence, which led to them being absent for a few days to regain sobriety and then automatically discharged from the program.

Program staff stated they stopped reporting HCHV1 and HCHV2 metrics in February 2023 because their contracted residential facility was sold. Although staff solicited bids for a new

[57] Community agencies conduct outreach, identify homeless individuals, and create a list of their names known as the By Name List.

[58] 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*.

contract, they had been unable to find a new vendor offering acceptable terms. Consequently, program staff relied on community partners to temporarily house veterans. However, these partners also had limited funding and placement options, and this support decreased available resources for homeless services.

Program staff said that after enrolling homeless veterans in the program, they screen and assess them during weekly program meetings. Staff identify issues and address them by referring veterans to VA or community services and using formal consults for healthcare services at the facility. Staff also work with the Veterans Benefits Administration office to develop new processes to help homeless veterans who are eligible for VA benefits but had never received them. Veterans Benefits Administration staff came on-site once a week to meet with homeless veterans scheduled for VA benefit consultations and those who walk in during available times. For those who are not eligible for VA benefits, program staff enter their information into the Homeless Management Information System to facilitate access to community-based programs.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[59] 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.[60]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[61] The program met the performance measure target for FY 2023. The Veterans Justice Outreach Coordinator used a specialized system that provided a current list of veterans in custody at specific jails. The number of jails in Salem that used the system had grown considerably in the year prior to the OIG site visit, making outreach to incarcerated veterans more efficient. Jail administrative personnel also referred veterans to the program and facilitated program staff's access to incarcerated veterans.

The Veterans Justice Reentry Specialist reported meeting with veterans at biannual prison resource fairs, and after they are released, meeting at local probation offices. The coordinator cultivated relationships with community partners and attended events to speak to groups about the program.

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

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

[61] 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*.

Meeting Veteran Needs

Program staff described conducting outreach visits at several jails, detention centers, and courts in their service area. They reported sometimes driving hours to meet with veterans, often with limited notice, and expressed concerns that vehicles might not be available when requested. Program staff noted that missing visits due to lack of transportation could be detrimental to relationships formed with incarcerated veterans and prison personnel.

Staff also participated in veterans treatment courts, which have authority over veterans involved in the justice system and provide substance use disorder treatment and recovery support services in a supervised environment. Program staff referred enrolled veterans to VA and non-VA treatment services, housing programs, VA's Supportive Services for Veteran Families, and employment services.[62] Program staff also entered consults for primary care, emergency medical care, and mental health and substance use disorder treatment.

Additionally, staff reported providing case management services for veterans in treatment courts. For veterans entering incarceration directly from the facility's medical or residential units, staff implemented a performance improvement project through jails to provide a three-day supply of prescribed medications to veterans at discharge.

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."[63] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[64]

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

[62] The Supportive Services for Veteran Families "program provides supportive services to very low-income Veteran families in or transitioning to permanent housing." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

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

to the facility that are being used by veterans or their families (performance measure HMLS3).[65] Beginning in FY 2021, the program did not meet the target until September 2023. The program coordinator stated the lack of affordable housing was one barrier to meeting the target; the average cost of rental units was $100 to $200 above the voucher amount, and some landlords chose to rent at market value rather than participate in the program. To address this issue, program staff had hired a housing specialist, a new position partly focused on engagement with landlords. Another barrier to meeting the target was that some veterans left the program after receiving housing vouchers because they experienced mental health issues, relocated and lacked a phone to maintain contact, or chose not to comply with the case management requirements.

The coordinator described the program's receipt of 26 new vouchers as a strength of the program, but the additional vouchers may keep the facility from meeting the target for FY 2024. However, the team had strong relationships with community partners who identified and referred veterans to the program, and staff met weekly to assess homeless veterans who might be eligible for the services. Recently, after a veteran was hospitalized in another state, missed their monthly rent, and received an eviction notice, the program coordinator identified community resources to pay the rent and late fees, and the landlord stopped the eviction. As a result, the veteran was able to remain in the program and not return to homelessness.

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).[66] The OIG found the program exceeded the target for FYs 2021 through 2023. The program supervisor credited the success to the facility's Employment Specialist. The Employment Specialist, as well as Disabled Veterans Outreach Program and Homeless Veterans' Reintegration Program staff met regularly to review Homeless Management Information System data for veteran and employment status to track unemployed veterans until they find employment. Even though the program exceeded the target, the Employment Specialist continued looking for ways to improve it. Staff plan to begin integrating veterans who are not counted in the metric, such as those who were disabled or retired, and referring them to the Employment Specialist.

[65] VHA sets 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*.

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

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and 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.

OIG Recommendations and VA Responses

Finding: Emergency Department diversion and overcrowding statistics have worsened since the Emergency Department construction project began in 2019.

Recommendation 1

The Executive Director mitigates the impact of construction on patient care in the Emergency Department.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

The Emergency Department had remained in the same space since the late 1970's and has been modified on at least two previous occasions to suit the needs of Salem's Veteran population. The current construction project was initiated when the facility identified the need to, once again, expand services and enlarge the space to better serve Veterans. Throughout construction the capacity to treat Veterans presenting to the ED remained unchanged. There was a minor delay in the construction project when a design modification needed to be made so that utilities in the new addition could be connected with existing infrastructure. A resolution to the utility connection has been determined and the Emergency Department expansion is now expected to be complete by July 31, 2025, with activation/occupancy by the end of August 2025.

Monthly updates will be reported to the Space Committee regarding progress towards opening of the Emergency Department with quarterly reports to the Administrative Executive Council.

Finding: Toxic Exposure Screening Navigators did not have a process for reviewing veteran screening information for accuracy and were unable to determine if there was a backlog.

Recommendation 2

The Chief of Staff ensures the toxic exposure screening navigators verify data to track veterans waiting for secondary screenings and address any backlog.

__X__ Concur

____ Nonconcur

Target date for completion: June 30, 2025

Director Comments

The National TES Office completed work on the reporting system that eliminated the redundancy of duplicate entries. An additional TES Navigator position was added to address outstanding secondary screens. A review of pending secondary screens was completed and the backlog corrected. TES Navigators complete a weekly review of the Power BI VSSC PACT Act Toxic Exposure Screen Dashboard and address any incomplete secondary screens. As of Friday, December 27, 2024, per the Toxic Exposure Screening (TES) Follow-up Progress Report, the dashboard reflects only four current unresolved TES follow-up screens with two of those being greater than 30 days old.

There will be a monthly meeting with Chief of Staff, Chief of QM [Quality Management], and TES Navigators to review Power BI data for the following data points: number of unresolved TES follow-up secondary screens, number of resolved TES follow-up secondary screens, number of TES follow-up screen not completed greater than 30 days, and the % of TES follow-up screens completed. Compliance will be monitored until the number of resolved TES follow-up screens is 90% per month for six consecutive months. Numerator=number of resolved TES screens. Denominator=number of unique Veterans requiring TES follow-up. Reporting of TES data will be reported to Quality, Patient and Safety Council monthly.

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 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 March 26 through 28, 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.

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

[2] The OIG received seven responses representing eight VSOs: Veterans of Foreign Wars, Disabled American Veterans, American Red Cross, Roanoke Valley Veterans Council, American Legion, Lynchburg Area Veterans Council, Military Order of the Purple Heart, and the Associate of the US Army, Allegheny Blue Ridge Chapter.

[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
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	Veteran population estimates are from the Department of Veterans Affairs' Veteran Population Projection Model 2018.
	Homeless Population	Point-in-time (PIT) estimates offer a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Point-in-time (PIT) estimates offer 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 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 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 persons to the civilian labor force.
	Veteran Unemployed in Civilian Workforce	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.

Category	Metric	Metric Definition
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).
Transportation	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.
Access to Health Care	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.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

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

Table B.2. Health of the Veteran Population*

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

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

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

Appendix C: Facility Photographs

Figure C.1. *Navigation options.*
Source: Image obtained by OIG Inspector.

Figure C.2. *Symbols, colors, and branding for Salem facility.*
Source: Image obtained by OIG Inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 7, 2025

From: VA Mid-Atlantic Health Care Network Director, VISN 6 (15N6)

Subj: Healthcare Facility Inspection of the VA Salem Healthcare System in Virginia

To: Director, Office of Healthcare Inspections (54HF01)
Director, GAO/OIG Accountability Liaison (VHA 10OIC GOAL Action)

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Salem VA Health Care System in Virginia.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Salem VA Medical Center Leadership. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

   (Original signed by:)

   Paul S. Crews, MPH, FACHE

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 27, 2024

From: Director, VA Salem Healthcare System (658)

Subj: Healthcare Facility Inspection of the VA Salem Healthcare System in Virginia

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the *Salem VA Health Care System in Virginia*.
2. I have reviewed the report and concur with recommendations 1 and 2. Action plans have been developed or implemented and are identified in the Director Comments.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the Chief, Quality Management.

(Original signed by:)

Rebecca Stackhouse, CTRS, FACHE
Executive Director, SVAHCS

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