US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction

Healthcare Facility Inspection	24-00595-93	April 10, 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 Western Colorado Healthcare System (facility) from May 7 through 9, 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 (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders and staff both identified concerns related to the laboratory department and resulting changes to facility services as a significant system shock. Leaders explained that following a for-cause Joint Commission survey, VHA's National Enforcement Office identified issues in the laboratory, such as lack of leadership and critically low staffing levels during the night shift, and therefore closed overnight laboratory services. This closure resulted in the temporary suspension of inpatient, emergency, and some surgical services until November 2022. In May 2024, the laboratory had a compliance audit and received six more citations; however, staff corrected the deficiencies, and the National Enforcement Office removed the laboratory restrictions in June 2024.

Facility staff generally had positive perceptions of their work environment and felt safe reporting problems. However, staff had varying opinions about whether executive leaders' communication

[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.

was useful. Leaders said they are committed to clear communication and hold various meetings and publish a weekly newsletter to share information with staff.

Veterans service organizations' opinions generally indicated leaders were effective in dealing with veterans' issues.[2] Leaders explained that patient advocates work with staff to resolve veterans' concerns.[3]

Overall, the OIG found that executive leaders focused on making the facility a high reliability organization by encouraging open and clear communication; fostering a culture where staff feel comfortable suggesting ways to improve their work environment; addressing concerns; and using an electronic dashboard to monitor operational concerns, such as staffing losses and recruitment time projections.[4]

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 and compared findings from prior inspections to determine if there were recurring issues.

The OIG observed a public transit stop near the parking lot and found the facility offered adequate parking options and a welcoming main entrance. Although the main entrance lacks specific design features for visual and hearing impaired veterans, such as braille text on directional signs and audio cues, the features are available in the elevators. Additionally, information desk volunteers assist veterans in navigating the facility.

For toxic exposure screenings required by the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act, the OIG determined the facility had a process to screen veterans without a scheduled appointment.[5] However, the OIG identified over

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

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

[4] "High reliability organizations (HROs) experience fewer than anticipated accidents or events of harm, despite operating in highly complex, high-risk environments," as a "result of active employee engagement in demonstrating HRO Principles and behaviors." Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022. Tiered huddles "are a series of improvement-focused huddles that take place every day across a hospital or health care system" "that follow a hierarchical" path connecting teams, services, and leadership. Department of Veterans Affairs, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024. Leaders at the facility use an electronic dashboard that contains performance measure outcomes, process improvement data, and patient safety events at the executive leaders' daily tiered huddle, and the dashboard is accessible to all staff.

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

300 incomplete secondary (follow-up) screenings. The Associate Chief of Staff, Primary Care said staff would address these unresolved screenings during the veterans' next appointments; however, the OIG recommends executive leaders evaluate this process and develop a sustainable action plan to ensure staff complete the screenings.

The OIG found staff did not inspected a portable fire extinguisher in the Intensive Care Unit each month. The OIG also identified that other fire extinguisher inspection logs did not show staff had inspected the equipment, as required.

The OIG team also identified multiple deficiencies in the areas inspected: failure to conduct preventive maintenance inspections of medical equipment; lack of a process to clean and disinfect wheelchairs between patients' use; accumulation of dust on ceiling vents in patient treatment rooms; wall punctures and wallpaper damage; storage of clean equipment and medical supplies in dirty utility closets; inability of staff to consistently access medical equipment in a storage closet; and failure to ensure video monitors are used for patient safety purposes and only visible by staff directly involved in the patient's care. The OIG made several recommendations related to environment of care findings, including a recommendation for Veterans Integrated Service Network leaders to ensure executive leaders provide effective oversight of the facility's environment of care program.[6]

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. After an external audit revealed a contract pathologist did not consistently notify ordering providers of test results that indicate the presence of new cancerous cells within two business days, per the VHA Pathology and Laboratory Medicine policy, the Chief of Staff initiated a rapid process improvement workgroup. The workgroup developed a local policy that aligned with VHA guidance, and staff implemented a monitoring process to ensure the contract pathologist's sustained compliance.[7]

The OIG found the facility had a process to communicate urgent, noncritical test results. However, staff could not confirm if the process to ensure ordering providers notified patients of results timely was effective. The OIG recommends quality management staff implement a system-wide process to monitor the effectiveness of the patient notification of urgent, noncritical test results.

[6] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[7] VHA National Pathology and Laboratory Office, *Guide.4 New Malignancy Notification Policy,* January 30, 2024.

The OIG determined that staff are working toward establishing strong quality improvement processes. Staff discussed several activities to identify opportunities for improvements, including reviewing patient safety events and informing executive leaders and attending patient safety forums. Quality management staff said they experienced significant turnover in their department over the past six years but received support from executive leaders and hired well-qualified staff, which improved patient safety processes.

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 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 OIG found that executive and primary care leaders were aware of staffing shortages, mainly among teams in the Grand Junction clinic. With the support of the executive leaders, primary care leaders effectively managed panel sizes among the 23 teams and used float staff and clinical deployment teams to cover vacant positions.[8] Executive leaders approved an expansion of the Montrose clinic to increase the number of primary care teams and patient capacity. The OIG found the PACT Act and current staff vacancies had not affected patients' timely access to care.

Additionally, primary care staff are engaged in employee-driven process improvement projects aimed at optimizing clinic workflows. For example, they established a walk-in service where nurses assist patients with activities like refilling medications or scheduling appointments, which decreased interruptions to teams' daily workflow.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the programs have close collaborative relationships with community partners to help identify veterans who need housing and assist with resources for health care, food, and clothing. Staff also operate a walk-in clinic, where they assess homeless veterans' needs and refer them for appropriate services.

While minimal housing availability within the program's voucher limit posed a challenge, the OIG found program staff had been successful in engaging landlords to keep veterans housed.

[8] Clinical deployment teams consist of "permanent clinical staff" who "are highly skilled, trained in emergency response, and deployment-ready." to provide services to VHA facilities when needed. "Welcome to the CDT [Clinical Deployment Teams] Program Site," VHA Clinical Deployment Teams, accessed January 16, 2025, https://dvagov.sharepoint.com/sites/CDT. (This web page is not publicly accessible.) Float staff are designated facility providers and nurses who are available to provide coverage in case of clinic staff emergency absences.

The Housing and Urban Development–Veterans Affairs Supportive Housing program staff discussed the projection for the local community to achieve "functional zero" veteran homelessness by November 2024.[9]

What the OIG Recommended

The OIG made eight recommendations.

1. Executive leaders evaluate the toxic exposure screening process and develop a sustainable action plan to ensure staff complete secondary screenings.
2. Executive leaders ensure facility staff conduct all required monthly and annual fire extinguisher inspections, document the completion date and results, and report compliance rates to the Comprehensive Environment of Care Committee.
3. Executive leaders ensure facility staff complete preventive maintenance inspections for all medical equipment.
4. Executive leaders ensure facility staff develop and implement processes to properly disinfect wheelchairs, remove dust from ceiling vents, and repair walls.
5. Executive leaders ensure facility staff keep clean and dirty equipment and supplies separated in storage areas and ensure staff can access medical equipment when needed.
6. Executive leaders ensure facility staff use video monitors for patient safety purposes only and limit them to staff directly involved in the patient's care.
7. Veterans Integrated Service Network leaders ensure facility executive leaders provide effective oversight of the environment of care program.
8. Executive leaders ensure quality management staff implement a system-wide process to monitor the effectiveness of patient notification of all urgent, noncritical test results.

[9] "Functional zero for veteran homelessness means that fewer veterans are experiencing homelessness than can be routinely housed in a month, with a minimum threshold of 3 veterans." "Functional Zero," Community Solutions, accessed June 6, 2024, https://community.solutions/built-for-zero/functional-zero. This facility reaches functional zero when there are three or fewer unsheltered veterans.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Executive Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, 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.

JULIE KROVIAK, M.D.
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

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

FACILITY IN CONTEXT

VA Western Colorado Healthcare System
Grand Junction, Colorado
Level 3-Low Complexity
Mesa County
Hospital Referral Region: Grand Junction

Description of Community

POPULATION

Female **213,077**
Veteran Female **2,429**
Male **217,831**
Veteran Male **24,151**
Homeless - State **10,397**
Homeless Veteran -State **738**

MEDIAN INCOME

$64,090

EDUCATION

91% Completed High School
65% Some College

VIOLENT CRIME

Reported Offenses per 100,000 | **152**

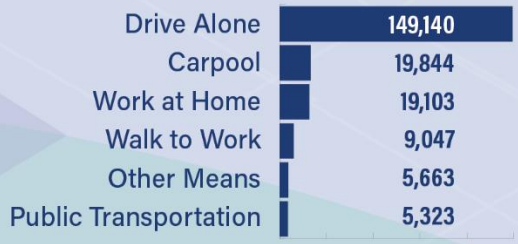
SUBSTANCE USE

27.6% Driving Deaths Involving Alcohol
18.8% Excessive Drinking
57 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
3% Veterans Unemployed in Civilian Workforce

TRANSPORTATION



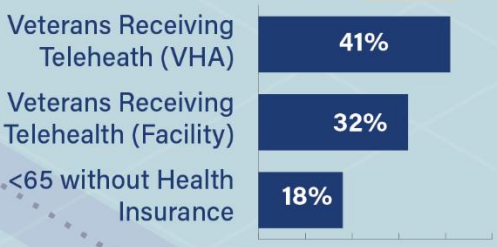
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**82.5 Minutes, 72.5 Miles**
Specialty Care	**107 Minutes, 113.5 Miles**
Tertiary Care	**231.5 Minutes, 233 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **4,398**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

3,451

38 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.86 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
29	56

Health of the Facility

UNIQUE PATIENTS

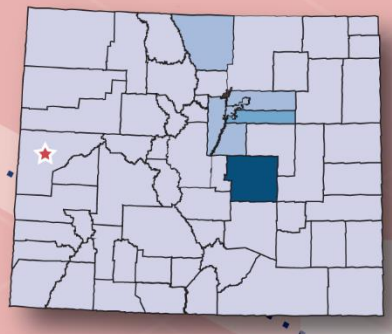
Unique Patients VA and Non-VA Care	15K
Unique Patients VA Care	14K
Unique Patients Non-VA Care	10K

COMMUNITY CARE COSTS

Unique Patient $20,368	Outpatient Visit $301
Line Item $1,847	Bed Day of Care $320

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.82%
Facility Total Loss Rate	12.41%
Facility Retire Rate	1.89%
Facility Quit Rate	9.81%
Facility Termination Rate	0.63%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.02% 5.15% 10.25% 15.35% 20.45% 25.54%

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.

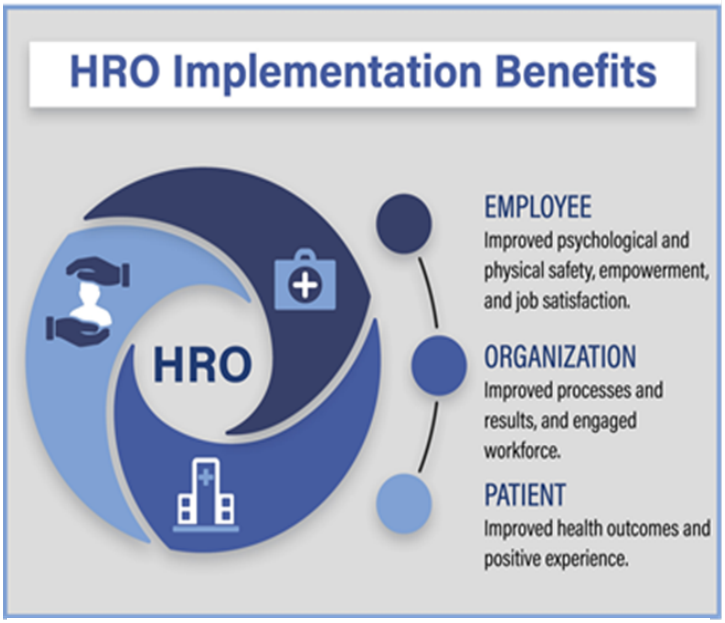
HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and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

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

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]



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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient

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

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

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

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

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

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

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

PACT Act

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

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

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

[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. As of May 1, 2023, VA's website contained this information (it has since been removed from their website).

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; 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.

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 Grand Junction VA Medical Center, part of the VA Western Colorado Healthcare System (facility), was built on 40 acres of land purchased in 1945 for one dollar to care for World War II veterans. The Medical Center was built in two years, from 1947 to 1949, and the first patient was admitted on May 16, 1949. The facility includes the main medical center and four outpatient clinics in Colorado and Utah.

At the time of the inspection, the facility had an executive leadership team consisting of a Medical Center Director (Director), Chief of Staff, Associate Director for Patient Care Service, and Associate Director. The Director, who joined the team in June 2020, was the most tenured leader. The newest member, the Associate Director, was appointed in October 2023. In fiscal year (FY) 2023, the facility's budget was approximately $305 million, and it had a total of 65 operating beds (25 hospital, 31 community living center, and 9 substance abuse residential rehabilitation treatment program), serving more than 15,000 enrolled veterans.[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 20, 2024, https://www.va.gov/VA_Community_Living_Centers.

[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.

Based on responses to the OIG's questionnaire and interviews with executive leaders, the OIG learned that significant changes to the facility's services due to issues with the laboratory department was a system shock. In February 2022, an unannounced for-cause Joint Commission survey raised concerns about the quality and safety of the facility's laboratory operations, such as missing reviews of quality metrics, questions about staff competencies, and an unclear process describing how tests would be performed after hours.

In March 2022, the VHA Pathology and Laboratory Medicine Service's National Enforcement Office confirmed the concerns and identified additional issues, such as the absence of an on-site laboratory director, lack of laboratory leaders who had knowledge of required policies and procedures, and critically low staffing levels for medical technologists. As a result, VHA's National Enforcement Office sanctioned restrictions on the laboratory that required executive leaders to close overnight laboratory services until leaders could make corrective actions to address these safety issues. This closure required facility staff to transfer all admitted inpatients to community hospitals, close the Emergency Department during overnight hours, and postpone surgeries requiring post-operative admission to the facility.

The executive leaders said that prior to FY 2020, the previous leadership team had neglected the laboratory department's ongoing challenges with staff retention, which had negatively affected their ability to maintain sufficient staffing levels to support operations and perform quality assurance tests. The leaders further reported that during the COVID-19 pandemic, more staff left the laboratory department for less stressful positions in the community, and staffing levels were not sufficient to consistently support operations during the overnight shift. Leaders explained that local community hospital staff performed laboratory testing for the facility during those hours.

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

[18] 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*.

In November 2022, after facility staff showed compliance with the immediate improvement plans, VHA's National Enforcement Office authorized facility leaders to fully reopen laboratory, Emergency Department, and surgical services and to admit patients to the hospital. The enforcement office continued monitoring the facility's laboratory department operations and completed a follow-up compliance audit the week of May 20, 2024, that resulted in six additional citations, but the laboratory was able to remain fully operational. On June 3, 2024, after verifying that laboratory staff had corrected all previous deficiencies and leaders had secured adequate staffing levels, the National Enforcement Office permanently removed the restrictions placed on the laboratory department.

The executive leaders reported believing the laboratory department challenges resulted in a difficult learning process for facility leaders and department staff but ultimately strengthened the department. Leaders also acknowledged this system shock caused stress for facility staff due to temporary reassignments from their usual work areas. For example, the inpatient and intensive care units closed due to the lack of laboratory support, and staff in those areas were assigned to different work locations. To support facility staff during this time, leaders said they were engaged and maintained ongoing communication with them to decrease their stress and unease. The laboratory leadership team said they continue to brief executive leaders weekly on department staff's actions to sustain improvements. Laboratory leaders also confirmed that executive leaders responded to their needs during the laboratory closure, especially by approving department staffing increases.

Executive leaders explained that as part of their HRO journey, they have learned from the mistakes made in the laboratory department and reinforced several processes, including the use of an electronic dashboard and daily tiered huddles where staff can report concerns.[19] The Director showcased the dashboard, which communicated information related to daily operations, adverse events and close calls, and construction projects. Leaders said they share information on the dashboard during tiered huddles to monitor operational concerns, like staffing losses and recruitment time projections. The Associate Director said executive leaders had built a culture where employees feel they can come forward if they see issues to mitigate future occurrences.

[19] A facility's "Journey to High Reliability represents a long-term commitment to both Veterans and the VHA workforce." Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025),* September 2022. Tiered huddles are "a series of improvement-focused huddles that take place every day across a hospital or health care system" "that follow a hierarchical path" connecting teams, services, and leadership. Department of Veterans Affairs, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024.

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]

EXECUTIVE LEADER COMMUNICATION
Executive leaders shared their communication goals are to listen to staff needs, take action to respond to feedback, and ensure staff are aware of leaders' efforts to meet their requirements.

EXECUTIVE LEADER INFORMATION SHARING
Executive leaders described Fireside (Fall/Winter) and Lakeside (Spring/Summer) chats with staff, weekly newsletters, and tiered huddles as initiatives they have taken to share information.

The OIG noted an improvement in VA survey scores for FYs 2021 through 2023 for leadership communication. However, based on OIG questionnaire responses, staff were divided about whether the communication was useful. Some staff indicated executive leaders seemed disconnected, giving the impression they were dismissive of staff's concerns and opinions. The questionnaire also revealed that some staff recognized leaders for conducting fireside chats, which are meetings where leaders address questions and recommendations to improve how they communicate; other staff said the time of these meetings was not convenient and conflicted with their work schedule, preventing them from participating.

When the OIG asked executive leaders about communication with staff, they reported being committed to open and clear communication through listening and responding to staff's needs and involving them in process improvement efforts. They also described publishing a *Weekly Happenings* newsletter as an effort to connect with staff.

The Director said executive leaders use daily tiered huddles to support process improvements. For example, the Associate Director shared that Veterans Integrated Service Network (VISN) staff recently began centralized temperature monitoring for refrigerators, and the facility's

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

[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*.

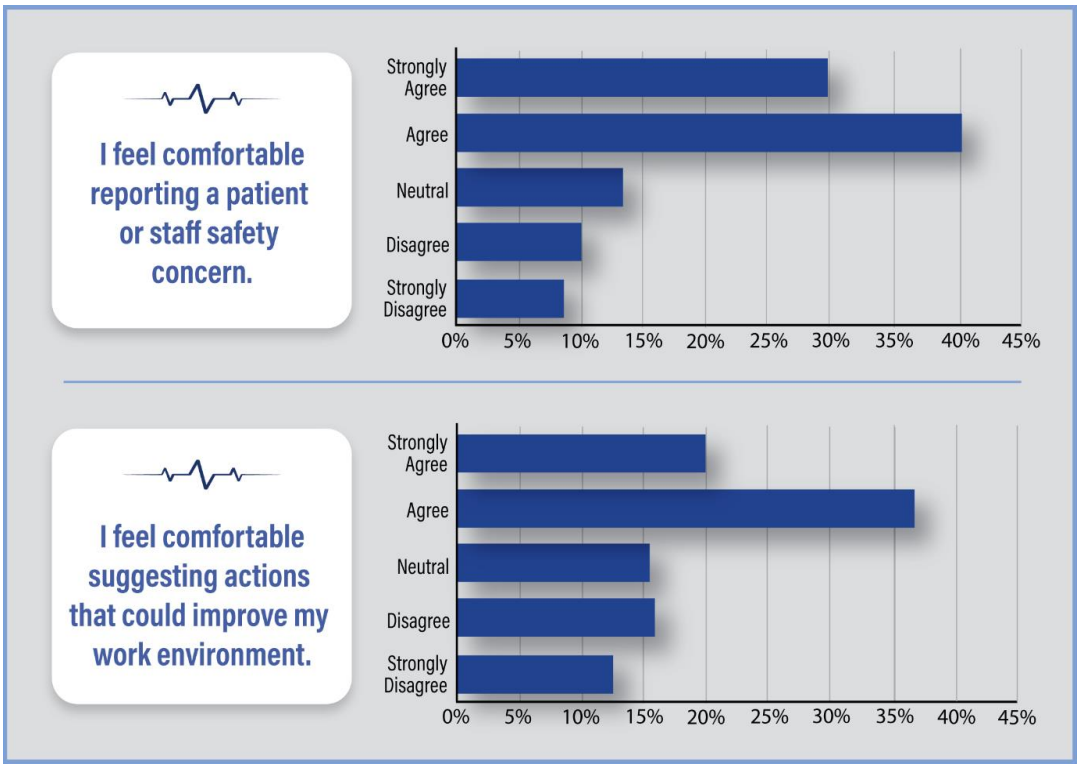
[22] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[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.

pharmacy staff observed they were not receiving alerts when temperatures were out of range.[24] The pharmacy staff discussed the issue during their department huddle, then elevated it to the executive leaders, who then communicated the concern to VISN leaders, who ultimately determined it was a VISN-wide problem. The VISN leaders alerted all affected facilities, resulting in staff implementing a work-around until leaders resolved the issue.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26]



[24] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[25] "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," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

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

The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

Based on questionnaire scores, the OIG found that employees generally felt comfortable suggesting ways to improve their work environment and reporting safety concerns. Additionally, VA survey scores related to fear of reprisal, supervisor trust, and perceptions of psychological safety steadily improved from FYs 2021 through 2023. The executive leaders attributed the improved psychological safety scores to facility leaders' commitment to a culture of zero harm.[27] Leaders said they encourage employees to share their concerns and actively participate in developing solutions when they identify issues.

Although employees generally had positive perceptions of their work environment, some expressed they would consider leaving the organization due to the lack of advancement opportunities, as well as limited monetary performance awards and retention incentives due to budgetary constraints. The Director confirmed that some employees left the facility due to lack of professional development opportunities and others left due to retirements. The Associate Director for Patient Care Service said leaders seek feedback from employees prior to their departure to identify opportunities to improve retention.

> The Associate Director explained that due to the facility's size, there were limited advancement opportunites. The leader recounted a personal story of starting at the facility, slowly advancing until there were no additional opportunites, which led to leaving the facility for a national position, before ultimately returning as the Associate Director.

Executive leaders explained that, until recently, they could offer some retention incentives, which had proved effective in maintaining low employee turnover, but VHA discontinued the incentives due to budgetary constraints.[28]

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.[29] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to

[27] Zero harm is an understanding that although errors will occur, leaders implement standards and practices to prevent patient harm "because even one patient harmed is one too many." Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Glossary of Terms*, August 2022.

[28] "Recruitment, relocation, and retention incentives (3Rs) are compensation flexibilities available to help Federal agencies recruit and retain a world-class workforce." "Recruitment, Relocation & Retention Incentives," Office of Personnel Management (OPM), accessed May 29, 2024, https://www.opm.gov/incentives.

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

veterans and their families.[30] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

The Director reported hosting a monthly meeting with congressional staff and the VSOs, including the local chapter of Disabled American Veterans. Executive leaders explained that when VSO representatives share veterans' concerns, the facility's patient advocates record and track them in the Patient Advocate Tracking System-Replacement.[31] The leaders further explained that patient advocates work with the appropriate department staff to resolve the concerns, but if they cannot, they seek support from executive leaders. VSO and patient advocate questionnaire responses indicated leaders are generally responsive to veterans' concerns.

Patient advocates and VSO representatives also shared veterans' concerns about PACT Act eligibility criteria, the toxic exposure screening process, and available benefits. In response, the Associate Director explained that administrative and patient advocate staff provided information to veterans in the community.

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.[32] 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.

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

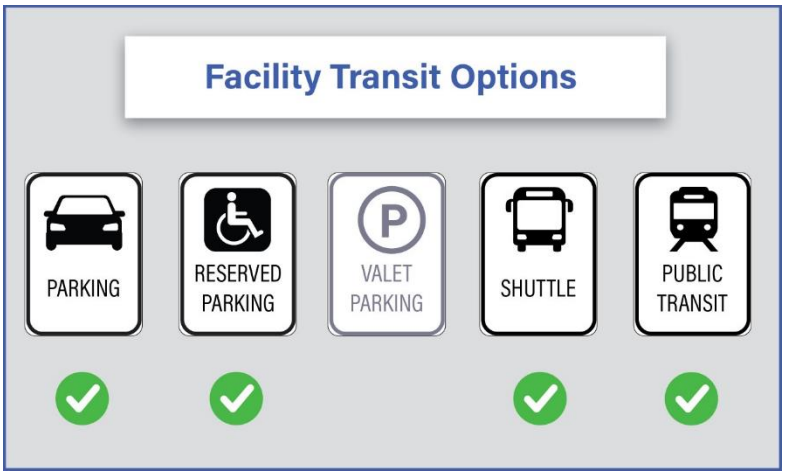
[31] The Patient Advocate Tracking System-Replacement "is a web-based application that supports Patient Advocates and VHA staff in tracking and trending Veteran complaints in one centralized repository." Veterans Health Administration Office of Patient Advocacy, *Veteran Centered Complaint Resolution Guidebook*, January 2023.

[32] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] 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.[34]

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.

The OIG team followed directions provided on the facility's website and was able to easily navigate to the facility and secure parking. The OIG observed a public transit stop near the entry to the parking lot, which is close to the main entrance. For those requiring assistance, the OIG verified that a volunteer-operated golf cart service transports veterans from their vehicles to the facility Monday through Friday from 8:00 a.m. to 4:00 p.m. The OIG determined the parking lot had a sufficient number of spaces, including some accessible for those with disabilities.[35]

[33] 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.

[34] 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.

[35] Access Board, *Architectural Barriers Act (ABA) Standards.*

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.[36]

The OIG observed that the main entrance was clearly marked by signage in the parking lot and on the building. The entrance was covered and equipped with power-assisted doors; had multiple wheelchairs available for patient use; and an information desk staffed by volunteers who immediately welcomed the OIG inspectors. Although the entrance was well-lit and clean, the OIG noted the flooring was worn. The Chief of Facilities Management Services said plans to remodel the main entrance area were placed on hold due to contracting issues, and leaders are discussing other options to move the project forward. The OIG also noted that veterans enter the Emergency Department from the main entrance; the Chief of Police stated that VA police grant them access after normal business hours.

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.[37]

The OIG observed volunteers at the information desk assisting veterans with directions. The OIG inspectors could easily find specific clinical and nonclinical areas using signs and directories posted on the walls.

[36] 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*.

[37] 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.[38] The OIG noted the main entrance lacked sound absorbing wall panels and specific features like braille text on directional signage as recommended by VHA interior design guidelines. However, the OIG confirmed that braille text and audio cues were available in the elevators to assist with navigation. Although the information desk volunteers had not received basic sign language training, they explained how they assist veterans with sensory impairments.

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.[39]

The OIG confirmed the facility had a team of toxic exposure screening navigators who monitor the facility's screening performance and educate providers and veterans and about the screenings.[40] During an interview, the navigators explained that veterans can access screening information online, through VA mobile applications, and from informational pamphlets provided by Public Affairs Office staff during outreach events. The Associate Chief of Staff, Primary Care shared that primary care staff screen most veterans during scheduled or walk-in appointments and refer them for secondary screenings if they report a toxic exposure.

[38] 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.

[39] 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.

[40] VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*.

The OIG reviewed the facility's data on toxic exposure screenings and found that staff had not addressed over 300 secondary screenings. When asked, the associate chief said staff would address these unresolved screenings during the veterans' next annual appointments. Failure to address secondary screenings can result in missed opportunities for veterans to receive care for toxic exposure. The OIG recommends executive leaders evaluate the toxic exposure screening process and develop a sustainable action plan to ensure staff complete secondary screenings.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[41] 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 noted the facility had action plans for open recommendations from the previous Joint Commission survey in January 2023 related to environment of care and life safety standards.[42] During the inspection, the OIG found a portable fire extinguisher in the Intensive Care Unit that did not show evidence staff completed a monthly inspection. The OIG also reviewed the facility's fire extinguisher inspection records and found the monthly and annual inspection logs did not have evidence staff completed the required inspections, which could lead to patient, staff, and visitor harm during a fire emergency.[43] During an interview, members of the Comprehensive Environment of Care Committee attributed the incomplete inspections to staffing shortages and explained they were securing a contract with a certified technician who would be responsible for the inspections. The OIG recommends executive leaders ensure staff conduct all required monthly and annual fire extinguisher inspections, document the completion date and results, and report compliance rates to the Comprehensive Environment of Care Committee.

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,

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

[42] Life safety standards help "organizations minimize fire hazards and provide a system of safety in case of fire." The Joint Commission, "Life Safety Code Requirements for Behavioral Health Care," accessed October 15, 2024, https://www.jointcommission.org/life-safety-code-requirements-for-behavioral-health-care.

[43] The Joint Commission requires annual maintenance checks and monthly inspections of portable fire extinguishers. The Joint Commission, *Standards Manual*, E-dition, EC.02.03.05, January 14, 2024.

outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The Joint Commission requires medical facilities to ensure staff inspect, test, and maintain medical equipment.[44] The OIG observed multiple instances of medical equipment lacking inspection completion stickers or having stickers indicating overdue inspections. Medical equipment can malfunction or produce incorrect readings, which may result in patient harm. In an interview, Comprehensive Environment of Care Committee members said staff inspected high-risk equipment but experienced challenges with all other equipment. The committee members explained that staffing shortages were a contributing factor, but staff had selected candidates for two open technician positions. The OIG recommends executive leaders ensure facility staff complete preventive maintenance inspections for all medical equipment.

The Joint Commission also requires facility staff to reduce infection risks.[45] The OIG did not observe evidence, such as a tag or sticker, that staff cleaned wheelchairs at the main entrance and Community Living Center between patients' use. The OIG also noted the lack of disinfectant supplies available in the immediate areas.

The OIG also noted the accumulation of dust on ceiling vents in several patient treatment rooms and punctures in walls in the Primary Care Clinic, as well as peeling wallpaper in the Community Living Center. These deficiencies can prevent proper cleaning and increase infection risks for both patients and staff. When asked about the deficiencies, staff reported being unaware of a process to ensure they clean wheelchairs between patients' use. The Chief of Facilities Management Service shared that leaders recently filled a vacant position needed to support ongoing maintenance. The OIG recommends executive leaders ensure facility staff develop and implement processes to properly disinfect wheelchairs, remove dust from ceiling vents, and repair walls.

During inspections in the Emergency Department, Intensive Care Unit, and Community Living Center, the OIG observed staff storing clean equipment and medical supplies in dirty utility closets. Additionally, the OIG noted the Emergency Department's clean equipment room was located within an occupied patient treatment room. The OIG is concerned that clean equipment and supplies may be contaminated when staff store them in dirty utility closets, and Emergency Department staff may not be able to access equipment when needed. Facility staff said space limitations contributed to improper storage of equipment and medical supplies. The OIG recommends executive leaders ensure facility staff keep clean and dirty equipment and supplies separated in storage areas and ensure staff can access medical equipment when needed.

[44] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.01, January 14, 2024.

[45] The Joint Commission, *Standards Manual*, E-dition, IC.02.02.01, July 1, 2022.

VHA allows patient video monitoring for safety purposes but requires staff to ensure only those responsible for the patients' care can access and view monitors.[46] The OIG observed unattended video monitors at several nurse workstations on the Medical Surgical Unit. The monitors displayed patients in their rooms and were visible to staff and visitors on the unit. When staff fail to protect patients' privacy, it may erode the trust between patients and the organization. Nursing staff said they used the monitors during the COVID-19 pandemic to view patients without entering their rooms to reduce risk of exposure. The Nurse Manager was unable to explain why they continued to use the monitors and acknowledged staff did not follow the facility's policy. The OIG recommends executive leaders ensure facility staff use video monitors for patient safety purposes only and limit them to staff directly involved in the patient's care.

Overall, based on observations, review of the Environment of Care Committee minutes and inspection records, and interviews with committee members, the OIG was unable to validate executive leaders provided effective oversight of the environment of care program. The OIG would expect executive leaders to ensure facility staff have processes to meet accreditation and oversight standards, implement improvement actions, and build and maintain a robust environment of care program. The OIG recommends Veterans Integrated Service Network leaders ensure facility executive leaders provide effective oversight of the environment of care program.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[47] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[46] "A patient safety purpose exists when a VA health care provider reasonably believes that there is a likely and serious safety risk to a patient and monitoring of the patient's actions is needed to ensure VA health care providers can take immediate action to intervene." VHA Directive 1078, *Privacy of Persons Regarding Photographs, Digital Images and Video or Audio Recordings*, November 29, 2021.

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

diagnostic and ordering provider teams and their patients.[48] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined that clinical leaders had procedures for communicating urgent, noncritical test results to ordering providers and patients. Specifically, leaders said providers receive view alert notifications in the patient's electronic health record for these test results.[49] They further clarified that if the ordering provider or designee does not address the results within 72 hours, the electronic health record system automatically forwards the alert to the provider's clinical service leader for resolution. Leaders also said they recently implemented a process to automatically generate a letter with the patient's test results and mail it to them within seven days to meet VHA's requirements for patient notification.[50] The Chief of Staff emphasized that despite this process, providers still need to speak with patients to discuss results that require follow-up.[51]

When the OIG asked whether there were challenges with the communication of test results process, the clinical leaders stated that providers from VHA's National Teleradiology Program, which the facility uses to interpret diagnostic images after hours and on weekends, occasionally did not give ordering providers timely results.[52] The leaders explained that ordering providers have a positive relationship with the teleradiology program staff, who have a heavy workload due to supporting other VA medical facilities. With the executive leaders' support, the clinical leaders reported working to secure an additional teleradiology contract to ensure ordering providers receive timely results. Therefore, the OIG made no recommendation.

The OIG determined the facility's recently updated policy did not include a process for staff to monitor and document the effectiveness of the patient notification process and address any performance issues, as required by VHA.[53] During an interview, the OIG learned that staff

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

[49] View alert notifications are alerts for specific patients, such as lab result notifications, that appear on the patient's electronic health record. VA Manual, *Computerized Patient Record System (CPRS) Technical Manual: GUI Version*, April 2024.

[50] VHA requires the "medical facility ordering provider or designee" to communicate test results requiring potential actions or therapeutic intervention options with the patient "within 7 calendar days from the date on which the results are available to the ordering provider or designee." VHA Directive 1088(1).

[51] VHA requires "when test results indicate that an action or therapeutic intervention is needed, the VA medical facility ordering provider or designee must discuss potential actions or therapeutic intervention options with the patient, and initiate the action." VHA Directive 1088(1).

[52] The VHA National Teleradiology Program "provides 24/7 diagnostic radiology services to Department of Veterans Affairs (VA) medical facilities located in all Veterans Integrated Service Networks (VISNs), rendering final diagnostic interpretations on a wide variety of modalities including computerized tomography scans (CTs), X-rays, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine imaging studies." VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

[53] VHA Directive 1088(1).

review External Peer Review Program data related to providers' timely communication of test results to patients and report notable trends to the Quality, Safety, and Values Board quarterly.[54] However, quality management staff said they do not have a system-wide proactive approach to monitor providers' compliance and acknowledged an opportunity to develop this process in the Primary Care Service and Emergency Department. The OIG recommends executive leaders ensure quality management staff implement a system-wide process to monitor the effectiveness of patient notification of all urgent, noncritical test results.

Action Plan Implementation and Sustainability

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

The OIG found the facility had no open recommendations for improvement from the previous OIG comprehensive healthcare inspection conducted in November 2020. During a Joint Commission survey in July 2023, the facility's laboratory department received a finding for a technician not reporting a critical test result to the ordering provider, as required. After reviewing documents provided by facility staff, the OIG determined that laboratory staff developed corrective action plans to address the finding, monitored improvement actions for sustained compliance, and reported progress to the appropriate oversight committee.

The Accreditation Manager reported facilitating audits at least every six months to ensure each department is meeting Joint Commission standards. The manager also emphasized that staff tracked, documented, and reported any recurring themes or issues through their oversight committees.

[54] The External Peer Review Program supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. "External Peer Review Program (EPRP)," VHA Office of Informatics and Analytics, March 15, 2022, https://department.va.gov/privacy/sites/ExternalPeerReviewProgram.pdf. (This website is not publicly accessible.)

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

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.[56] 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.[57] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Chief of Quality, Safety, and Value said the facility had no root cause analyses, sentinel events, peer reviews, or institutional disclosures related to communication of abnormal test results in the past three years.[58] The Patient Safety Manager reported reviewing all Joint Patient Safety Reporting system events to find repeat patient safety issues.[59] The manager also described communicating updates related to patient safety events twice a week during tiered huddles that are open to all staff and meeting with the executive leaders once a week to address any barriers in resolving issues. The Accreditation Manager reported conducting quarterly risk assessments, and the Patient Safety Manager added that the HRO Lead coordinates monthly patient safety forums to identify opportunities for process improvements.

As discussed in the Culture section above, a February 2022 Joint Commission unannounced for-cause survey raised concerns about the facility's laboratory operations that were confirmed by VHA's National Enforcement Office in March 2022. Facility staff showed compliance with improvement plans, and the National Enforcement Office authorized leaders to resume laboratory services in November 2022. However, according to the Accreditation Manager, the National Enforcement Office's follow-up audit in April 2023 revealed a contract pathologist did not consistently notify ordering providers of test results that indicate the presence of new cancerous cells (malignancy) within two business days.[60] The Accreditation Manager and

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

[57] VHA Directive 1050.01(1).

[58] Root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." "A sentinel event is any patient safety event (not primarily related to the natural course of the patient's illness or underling condition) that results in death, permanent harm or severe temporary harm." VHA Directive 1050.01(1); Peer review "is a critical review of care performed by a peer conducted in accordance with all applicable laws, regulations, [and] current VHA policies." VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024; Institutional disclosure "is a formal process by which VA medical facility leader(s), together with clinicians and other" appropriate individuals, "inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[59] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

[60] VHA National Pathology and Laboratory Office, *Guide.4 New Malignancy Notification Policy,* January 30, 2024.

Laboratory Supervisor acknowledged not being aware of this requirement, or that laboratory staff had not been monitoring the contractor's compliance.

The Accreditation Manager said that, in May 2023, laboratory staff began monitoring the contract pathologist's compliance monthly and confirmed inconsistencies with timely communication of patients' results to ordering providers. In September 2023, the Chief of Staff set up a rapid process improvement workgroup that developed a local policy to align with the national guidance, disseminated the new policy to facility staff, and educated them on the requirements. The supervisory medical laboratory scientist also ensured all patients with a new malignancy test result had been notified and had a plan of care. Additionally, the Medical Laboratory Director determined that patients had no adverse outcomes. The OIG confirmed laboratory staff had implemented a standardized monitoring process to ensure the contract pathologist improved and sustained compliance with notifying ordering providers of malignancy test results as required.

Quality management staff also reported their department had experienced significant staff turnover in the past six years, specifically in infection prevention, accreditation management, and patient safety positions, which made supporting a robust and sustainable continuous learning process challenging. Staff further shared that with support from current executive leaders, patient safety processes have improved since they hired experienced, well-qualified staff.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[61] 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.[62] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

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

[62] 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.[63] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG found the facility also offers primary care through four outpatient clinics located in Colorado and Utah, and care in rural areas in Colorado and Utah through a mobile clinic service.[64] Twenty-three primary care teams provide care in the outpatient and mobile clinics to support the veterans in the facility's coverage area.

VHA recommends a ratio of at least 3.0 full-time equivalent support staff to 1.0 full-time equivalent primary care provider.[65] Based on data reviewed from FY 2023 through the first quarter of FY 2024, the OIG determined that, on average, the primary care teams had 3.4 full-time equivalent support staff for every provider, consistent with VHA guidelines. However, in the OIG's questionnaire, the facility liaison reported several vacancies, including two primary care provider, three nurse practitioner, three registered nurse, three licensed practical nurse, and five medical support assistant positions, mainly among teams in Grand Junction, Colorado.

The Associate Chief of Staff, Primary Care reported the positions had been vacant for less than a year and were due to promotions, retirements, and departures for positions at non-VA hospitals. The associate chief further explained that recruiting providers in Grand Junction was challenging due to the high cost of living, lower VA pay compared to non-VA facilities, and lengthy hiring process, which can take approximately 12 to 18 months.

Primary care leaders and support staff said the vacancies had no impact on access to care because float staff and clinical deployment teams provide coverage when needed.[66] Leaders also said they approved funding for a contract travel nurse to cover a vacancy at one of the outpatient clinics. The Associate Chief of Staff, Primary Care also informed the OIG about their nurse practitioner residency program, which is a clinical apprenticeship where practitioners train at the facility and leaders recruit them after graduation.

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

[64] "A mobile medical unit was established in 2020 to focus efforts in support of rural veterans, which comprises 56.63% of total enrollees." Department of Veterans Affairs, *Facility Trip Pack*, updated January 4, 2024.

[65] VHA Handbook 1101.10(2). "The term *full-time equivalent employment (FTE)* is used to quantify employment as a function of hours worked rather than by the number of individual employees. One FTE is also known as one work year. The number of FTEs in an agency is calculated by determining the total number of regular straight time hours (i.e., not including overtime or holiday hours) worked by employees and dividing that figure by the number of compensable hours applicable to each fiscal year. One work year, or one FTE, is equivalent to 2,080 hours of work." Congressional Research Service, *Federal Workforce Statistics Sources: OPM and OMB*, updated June 28, 2022, https://sgp.fas.org/crs/misc/R43590.pdf.

[66] Clinical deployment teams consist of "permanent clinical staff" who "are highly skilled, trained in emergency response, and deployment-ready" to provide services to VHA facilities when needed. "Welcome to the CDT [Clinical Deployment Teams] Program Site," VHA Clinical Deployment Teams, accessed January 16, 2025, https://dvagov.sharepoint.com/sites/CDT. (This web page is not publicly accessible.) Float staff are designated facility providers and nurses who are available to provide coverage in case of clinic staff emergency absences.

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.[67] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[68]

The OIG determined that on average, primary care team panels were approximately 80 percent full from October 2022 through December 2024. At the time of the OIG inspection, the Associate Chief of Staff, Primary Care reported most primary care team panels had increased to between 87 and 95 percent full due to recent vacant positions for providers. A primary care provider said that primary care leaders assigned additional patients to their panels due to the vacancies, but they have been able to manage the increased workload.

The associate chief shared that two teams in the Montrose clinic are at full capacity, and the lack of clinic space prevented them from adding another team. In response, executive leaders approved the expansion of the Montrose clinic and temporarily assigned new veteran enrollees to the Grand Junction clinic, or staff referred them to community care, until the construction is completed sometime in December 2024.[69] In addition, the associate chief said primary care staff at the Grand Junction clinic adjusted their work hours to offer additional appointment times to accommodate more patients.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[70] 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.

The Associate Chief of Staff, Primary Care reported working closely with the facility's health informatics staff to reduce the number of clinical reminders in electronic health records to improve efficiency for primary care providers. The associate chief explained that primary care staff review all clinical reminders with the informatics staff to identify and remove outdated or unnecessary reminders. Additionally, informatics staff installed disease-specific order sets in the electronic health record system to simplify the ordering process. For instance, when a provider

[67] "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).

[68] VHA Directive 1406(1).

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

[70] VHA Handbook 1101.10(2).

enters a women's health consult, the system automatically generates a prompt to order a pap smear test.[71]

Primary care support staff mentioned that primary care and facility leaders support them by leading huddles with opportunities for staff to provide feedback and suggestions. For example, staff described an employee-driven process improvement project to optimize clinic workflow with a walk-in service, where licensed practical nurses answer patients' questions and assist them with refilling medications, obtaining medical supplies, and scheduling appointments with a registered nurse or provider. Leaders said the walk-in service has increased patient satisfaction and decreased primary care team interruptions. The executive leaders said they will continue to support primary care leaders' efforts to improve clinic workflow processes.

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. Leaders said that enrollments in certain geographic areas, like Montrose, increased and therefore they are expanding the Montrose clinic, renovating the Grand Junction clinic, and filling open clinical staff positions quickly to accommodate additional patients.

Despite the vacancies noted in the previous section, new and established patients had an average wait time of less than 20 days from October 2021 through May 2024, based on the patient's desired appointment date. Primary care team members also reported the addition of toxic exposure screenings had minimal impact on their workload or timeliness of care.

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

Health Care for Homeless Veterans

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

[71] A pap smear test is "a method for the early detection of cancer especially of the uterine cervix that involves the staining of exfoliated cells using a special technique which differentiates diseased tissue." *Merriam-Webster*, "Pap Smear," accessed June 18, 2020, https://www.merriam-webster.com/dictionary/paptest.

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[72]

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).[73] 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."[74]

The OIG noted that although the facility did not meet the performance target of 100 percent in FYs 2021 and 2022, program staff made strong efforts to engage with unsheltered veterans, and their year-end performance was 89 and 97 percent, respectively. When asked about efforts to improve their performance on the measure, the Community Integration Programs Manager described participating in the annual January point-in-time count with community partners to identify unsheltered individuals living in places such as parks, shelters, cars, and recreational vehicles.

Program staff also described operating a walk-in clinic, Monday through Friday from 9:30 a.m. to 12:30 p.m., where staff assess unsheltered veterans and refer those with urgent needs to appropriate services. Managers reported meeting with community partners every other week to discuss potential outreach opportunities, and program staff work with community partners and law enforcement officials, who provide contact information for veterans needing housing assistance.

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).[75]

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

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

[74] 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.

[75] 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*.

The Community Integration Programs Manager clarified that the performance measures do not apply to the facility's homeless programs because there are no contracted residential housing services or low-demand safe haven programs in their service area.[76]

The manager shared other program efforts to assist veterans with housing, such as

- referring veterans with immediate housing needs to the community shelter or providing them with camping gear as needed;
- educating facility staff from other areas, such as primary care, about available resources and how to refer veterans to the program; and
- helping veterans obtain documents like identification cards or driver's licenses.

The manager reported working with various community partners that assist in meeting the needs of veterans in the program with housing; health care; mental health care; substance use treatment; legal help; financial assistance with past due rent and utility bills; and resources like clothing, outdoor accessories, cell phones, and hygiene kits. The manager also said program staff participated in a monthly event with a community partner and provided food, clothing, and haircuts to unsheltered individuals.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[77] 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.[78]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[79] The OIG found that program staff did not meet the target in

[76] "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." "Low Demand Safe Havens (LDSH) are 24-hour staffed transitional residences with private or semi-private accommodations that target the population of hard-to-reach, chronically homeless Veterans with mental illness, many with SUD [substance use disorder] and when traditional residential treatment programs do not meet a Veteran's needs." VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022. The HCHV1 and HCHV2 performance measures include veterans discharged from contracted residential housing services or low-demand safe haven programs.

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

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

[79] 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*.

FY 2023.[80] As a result, the Veterans Justice Outreach Coordinator said program staff increased outreach and education to jail staff and legal and law enforcement officials. The coordinator also shared this performance measure does not fully capture program staff's efforts to engage unsheltered veterans, such as when they refer veterans who do not meet enrollment criteria for the justice program to other appropriate services.

Meeting Veteran Needs

During an interview, program managers said staff assess veterans' needs and help guide them to necessary services, including housing, substance abuse treatment, and legal aid. Managers reported the area does not have a veterans treatment court, but staff refer them to other court programs, such as those for driving under the influence, domestic violence, and adult drug cases.[81] To foster more positive interactions with the justice system, managers said they arrange meetings between local law enforcement staff and veterans.

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."[82] 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.[83]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[84] The OIG found program staff did not meet the performance target from

[80] The facility enrolled 17 of the 25 veterans targeted for the program in FY 2023.

[81] Veterans treatment courts "effectively integrate evidence-based substance use disorder treatment, mandatory drug testing, incentives and sanctions, and recovery support services in judicially supervised court settings that have jurisdiction over veterans involved in the justice system who have substance use disorders, including a history of violence and post-traumatic stress disorder as a result of their military service." "Veterans Treatment Court Program, Overview," Department of Justice, accessed April 21, 2024, https://bja.ojp.gov/veterans-treatment-court-program.

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

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

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

FYs 2021 through 2023.[85] The Community Integration Programs Manager said the low number of housing units available within the program's voucher amount was a contributing factor. The manager explained that program staff performed community outreach and engaged with landlords during FY 2022 to increase housing availability.

> The Community Integration Programs Manager reported that, after approximately five years in the Housing and Urban Development–Veterans Affairs Supportive Housing program, a chronically homeless veteran was able to successfully budget and manage their finances, including using VA benefits and services, to put a down payment on a home.

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).[86] The OIG found the facility met the target in FYs 2022 and 2023.[87]

The program case manager identified restrictions on pets, having a significant legal history, past evictions, or poor credit as barriers that affected veterans' ability to secure housing. Program staff also shared that community partners assist with helping veterans by covering some of their costs, such as for background checks, rental deposits, administrative and application fees, and supplying them with resources to prevent evictions. They also said community partners support veterans by providing food, dental and vision care, substance abuse treatment, and coffee and donut social events.

The program case manager described other ways facility and program staff support veterans, including holding monthly group sessions where staff from other departments educate veterans on nutrition and whole health and assisting them in obtaining cell phones to schedule appointments. The program manager reported that since spring 2022, program staff had met with landlords quarterly to inform them about the program, explaining it included access to an assigned VA case manager for any concerns. The program manager said this approach had been successful in keeping veterans housed. Finally, program staff said the community is projected to achieve "functional zero" veteran homelessness by November 2024.[88]

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[85] The program's performance metrics were 81 percent in FY 2021, 67 percent in FY 2022, and 78 percent in FY 2023.

[86] 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*.

[87] Program staff's performance metrics were 19 percent in FY 2021, 47 percent in FY 2022, and 50 percent in FY 2023. The VASH3 performance measure target was 45 and 47 for FYs 2021 and 2022, respectively.

[88] "Functional zero for veteran homelessness means that fewer veterans are experiencing homelessness than can be routinely housed in a month, with a minimum threshold of 3 veterans." "Functional Zero," Community Solutions, accessed June 6, 2024, https://community.solutions/built-for-zero/functional-zero. This facility reaches functional zero when there are three or fewer unsheltered veterans.

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: Facility staff had not completed over 300 secondary (follow-up) toxic exposure screenings.

Recommendation 1

The OIG recommends executive leaders evaluate the toxic exposure screening process and develop a sustainable action plan to ensure staff complete secondary screenings.

__X__Concur

____Nonconcur

Target date for completion: September 30, 2025

Director Comments

Western Colorado Health Care System Executive Leadership Team evaluated the Toxic Exposure Screening process on February 12, 2025, and identified the need for an additional Toxic Exposure Screening provider. The Executive Leadership approved the designation an additional Primary Care Provider to perform secondary screenings starting April 4, 2025. To accomplish this the Associate Chief of Staff, Primary Care is ensuring the necessary training will be provided to the provider by March 28, 2025. This will allow the outstanding secondary screens to be completed and to allow dedicated time to perform secondary screenings moving forward. The number of outstanding secondary screenings will be monitored monthly by the Associate Chief of Staff, Primary Care. The Accreditation Coordinator shall report monthly compliance data on a quarterly basis, to the Quality and Patient Safety Board, for Executive oversight beginning June 2025. Compliance shall be defined as the total number of overdue secondary toxic exposure screenings completed in the month (numerator); total number of overdue secondary toxic exposure screenings due in the month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent of secondary screenings that are due, are completed each month and sustained for six consecutive months.

Finding: Facility staff did not consistently inspect fire extinguishers, as required.

Recommendation 2

The OIG recommends executive leaders ensure facility staff conduct all required monthly and annual fire extinguisher inspections, document the completion date and results, and report compliance rates to the Comprehensive Environment of Care Committee.

__X__Concur

____Non-concur

Target date for completion: September 30, 2025

Director Comments

Western Colorado Health Care System Executive Leadership Team evaluated the process for monthly and annual fire extinguisher inspections on February 13, 2025. The Occupational Safety and Health Manager was designated for oversight and responsibility of performing timely completion of fire extinguisher inspections. Monthly the Occupational Safety and Health Manager shall report completion compliance metrics to the Medical Center Safety, Occupational Health, and Fire Prevention Committee with Executive oversight by the Associate Director beginning March 2025. Compliance shall also be reported by the Accreditation Coordinator, quarterly to the Quality and Patient Safety Board beginning June 2025. Compliance shall be defined as number of fire extinguishers inspected in each month (numerator); number of fire extinguishers scheduled to be inspected, in each month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

Finding: Medical equipment lacked inspection completion stickers or had stickers indicating overdue inspections.

Recommendation 3

The OIG recommends executive leaders ensure facility staff complete preventive maintenance inspections for all medical equipment.

__X__ Concur

____ Non-concur

Target date for completion: March 31, 2026

Director Comments

Western Colorado Health Care System Executive Leadership Team evaluated the process for completion of preventative maintenance inspections of medical equipment on March 3, 2025, identifying the need for an additional Biomedical Engineer to support preventative maintenance inspection completions. Since the May 2024 Office of Inspector General Healthcare Facility Inspection an additional Biomedical Engineer was hired on July 28, 2024. The Chief of Facilities Management Services has developed and implemented a plan as of March 3, 2025, directing the Biomedical Engineer staff to perform a minimum of five Preventative Maintenance inspections per day. This will allow the Biomedical Engineers the ability to complete current back log of Preventative Maintenance by September 1, 2025, prioritizing completion related to risk. The Lead Biomedical Engineer shall be responsible for tracking compliance metrics with inspection completions. Monthly the Chief of Facilities Management Services shall report completion

compliance to the Medical Center Safety, Occupational Health, and Fire Prevention Committee with Executive oversight by the Associate Director, beginning March 2025. The Accreditation Coordinator shall also report compliance quarterly, to the Quality and Patient Safety Board, beginning June 2025. Compliance shall be defined as the number of preventative maintenance inspections, past due and newly assigned, completed each month (numerator); number of preventative maintenance inspections, past due and newly assigned, scheduled to be completed each month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

Finding: Facility staff did not have a process to ensure they cleaned and disinfected wheelchairs at the main entrance and Community Living Center prior to patients' use. The OIG also noted additional infection risks, such as ceiling vents with accumulated dust in several patient treatment rooms, wall punctures in the Primary Care Clinic, and peeling wallpaper in the Community Living Center.

Recommendation 4

The OIG recommends executive leaders ensure facility staff develop and implement processes to properly disinfect wheelchairs, remove dust from ceiling vents, and repair walls.

__X__ Concur

____ Non-concur

Target date for completion: January 31, 2026

Director Comments

Western Colorado Health Care System Executive Leadership Team evaluated the findings related to Environment of Care on February 13, 2025. The Executive Leadership Team identified the need for oversight for the cleaning of wheelchairs and the need to have cleaning supplies at the point of use. The Chief of Environmental Management Services implemented wheelchair cleaning stations at main entrances of the main facility and the Community Living Center on February 27, 2025. The Chief of Environmental Management Services has been assigned the responsibility of developing a wheelchair cleaning policy for facility wide use by April 18, 2025. The responsible managers (Community Living Center, Ambulatory Surgery Clinic, Primary Care Clinics, Emergency Department, and Voluntary Services) are responsible for providing staff education on proper methods for cleaning wheelchairs between each patient use by May 1, 2025. The process of cleaning the wheelchairs will be monitored by the Infection Prevention Nurse with direct visualization of a minimum of thirty wheelchairs will be audited per month. Monthly the Infection Prevention Nurse shall report compliance to the Accreditation Coordinator. The Accreditation Coordinator shall report compliance quarterly, to the Quality Patient Safety Board, for executive leadership oversight, beginning June 2025. Compliance shall be defined as the

number of wheelchairs disinfected correctly, per policy (numerator); the number of wheelchairs needing disinfecting (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

The Comprehensive Environment of Care Coordinator has oversight of the Comprehensive Environment of Care program, including conducting Environment of Care Rounds and reporting identified Environment of Care non-compliances. The Chief of Facilities Management Service has developed and implemented a corrective action plan to ensure the repair of wall penetrations, prioritizing completion related to risk. The Chief of Facilities Management also developed a plan for mitigation of peeling wallpaper in the Community Living Center, either by removal, encapsulation, or other acceptable methods. The Chief of Environmental Services identified that certain ceiling vents are inaccessible by Environmental Service workers due to elevated recessed nature of the ceiling vents, therefore the staff was unable to complete required cleanings. Environmental Services staff were instructed to initiate a Facilities Management Services workorder to remove ceiling vent covers and allow access to the ceiling vent for additional cleanings, as needed. This communication was completed via department training by April 1, 2025. Compliance with mitigation of wall penetrations and ceiling vent dust shall be measured through the Comprehensive Environment of Care Rounds program. Monthly, the Comprehensive Environment of Care Coordinator shall report completion of identified Environment of Care non-compliances to the Medical Center Safety, Occupational Health, and Fire Prevention Committee with executive oversight by the Associate Director, beginning March 2025. The Accreditation Coordinator shall also report completion compliance quarterly to the Quality Patient Safety Board, beginning June 2025. Compliance shall be defined as the number of identified wall penetrations and dirty ceiling vent during Environment of Care Rounds that was corrected per month, per policy (numerator); the number of wall penetrations and dirty ceiling vent identified per month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

Finding: Facility staff stored clean equipment and medical supplies in dirty utility closets in the Emergency Department, Intensive Care Unit, and Community Living Center. Emergency Department staff also stored clean equipment in a patient treatment room, which may be occupied and inaccessible to staff.

Recommendation 5

The OIG recommends executive leaders ensure facility staff keep clean and dirty equipment and supplies separated in storage areas and ensure staff can access medical equipment when needed.

__X__ Concur

____ Non-concur

Target date for completion: September 30, 2025

Director Comments

Western Colorado Health Care System Executive Leadership Team evaluated the findings related to Environment of Care and supplies on February 13, 2025, and identified that clean disposable face shields and clean eye protection were being kept in the identified dirty utility rooms. Clean supplies found in the dirty utility rooms were removed as of February 27, 2025. The unit nurse managers provided verbal just-in-time staff education during the removal of clean supplies. The nurse managers are providing additional staff education related to proper placement of clean and dirty equipment and supply storage, to be completed by March 31, 2025. The Accreditation Coordinator developed a compliance audit process to ensure appropriate storage of clean supplies on February 24, 2025. The unit nurse managers shall conduct monthly inspections to demonstrate compliance sustainment. The Accreditation Coordinator shall track the completion of the monthly inspections and report compliance quarterly to the Quality Patient Safety Board, for executive leadership oversight, beginning June 2025. Compliance shall be defined as the number of monthly audits conducted with supplies being stored in the appropriate place (numerator); the number of audits completed per month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

The Emergency Department Nurse Manager will establish a Standard Operating Procedure for the storage and utilization of medical equipment when needed. The Nurse Manager will also provide staff education on the new Standard Operating Procedure for storage and utilization of medical equipment process. The Standard Operating Procedure and the staff education will be completed by May 31, 2025. The Accreditation Coordinator will report completion status of the Standard Operating Procedure and staff education to the Quality Patient Safety Board beginning June 2025, quarterly until both elements are completed.

Finding: The Medical Surgical Unit had unattended video monitors displaying patients in their rooms at several nurse workstations that were visible to staff and visitors in the unit.

Recommendation 6

The OIG recommends executive leaders ensure facility staff use video monitors for patient safety purposes only and limit them to staff directly involved in the patient's care.

__X__ Concur

____ Non-concur

Target date for completion: July 1, 2025

Director Comments

Western Colorado Health Care System Medical Surgical Nursing Leadership was notified of non-compliance by the Office of Inspector General Inspection Team related to the inappropriate use of video monitors during the inspection, on May 8, 2024. Acting upon notification, the Medical Surgical Nurse Manager removed all video monitors from use, securing them in the locked nurse manager office. The video monitors, with approval from nursing leadership, were sent to the facility's off-site warehouse for storage on June 14, 2024. The Accreditation Coordinator conducted monthly audits to assess for unauthorized use of video monitors, following the removal. Nine months of auditing were completed, July 1, 2024-March 10, 2025, one hundred percent compliance was identified. The Accreditation Coordinator shall report compliance metrics to the Quality Patient Safety Board, for executive leadership oversight, beginning June 2025.

OIG Comments

The OIG considers this recommendation open to allow leaders time to submit documents to support closure.

Finding: Executive leaders did not provide effective oversight of the environment of care program to ensure facility staff have processes to meet accreditation and oversight standards, implement improvement actions, and build and maintain a robust environment of care program.

Recommendation 7

The OIG recommends Veterans Integrated Service Network leaders ensure facility executive leaders provide effective oversight of the environment of care program.

__X__Concur

____Non-concur

Target date for completion: April 1, 2026

Director Comments

Veterans Integrated Service Network Comprehensive Environment of Care Coordinator and Deputy Network Director or designee will conduct monthly calls with facility Associate Director or designee to discuss barriers to accomplish resolution of outstanding Environment of Care items. The meeting will review Comprehensive Environment of Care program status and site visit findings, including both regulatory and programmatic. Meetings will be held monthly. Data tracking will utilize a data set that specifies the facility's outstanding Comprehensive Environment of Care findings list. Denominator will be the total number of items on the list, numerator will be the total number of items completed. Tracking will continue until the goal of ninety percent completion of items is reached and sustained for six consecutive months. Data

will be tracked with quarterly submissions to the Veterans Integrated Service Network 19 Healthcare Operations Committee until the goal is achieved.

In addition, VISN Comprehensive Environment of Care Coordinator will request the facility address the lack of completion of Comprehensive Environment of Care annual plan reviews and identify action items and areas for improvement. VISN will work with the facility to develop actionable goals and completion metrics based on the areas of opportunity identified.

Finding: Executive leaders did not ensure quality management staff have a system-wide process to effectively monitor the facility's process for timely patient notification of urgent, noncritical test results.

Recommendation 8

The OIG recommends executive leaders ensure quality management staff implement a system-wide process to monitor the effectiveness of patient notification of all urgent, noncritical test results.

__X__ Concur

____ Non-concur

Target date for completion: January 30, 2026

Director Comments

Western Colorado Health Care System Executive Leadership Team reviewed existing facility processes related to communication of test results on February 13, 2025. The Chief of Quality, Safety, and Value will collaborate with appropriate departments to develop and implement a randomized medical record audit process to monitor the timeliness and effectiveness of patient notification of all urgent, noncritical test results that require action by June 1, 2025. Monthly the Chief of Quality, Safety, and Value will perform a sampling of thirty randomized medical record audits each month and report the audit results to the Accreditation Coordinator. The Accreditation Coordinator shall report the monthly audit compliance quarterly, to the Quality and Patient Safety Board for executive leadership oversight, beginning September 2025. Compliance shall be defined as the number of charts with Veteran notification documented within required time frames as outlined in VHA Directive 1088 (numerator); the total number of charts reviewed each month (denominator). Monitoring and reporting shall continue until a minimum of ninety percent compliance is achieved and sustained for six consecutive months.

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from May 7 through 9, 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 a response from six VSOs (Vets Committee of Mesa County, State of Colorado Division of Military and Veterans Affairs, Eagle County Government, Eagle County Veterans Services, Mesa County, and an unidentified VSO).

[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	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

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).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	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 position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 21, 2025

From: Director, VA Rocky Mountain Network (10N19)

Subj: Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction

To: Director, Office of Healthcare Inspections (54HF05)

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 Western Colorado Healthcare System in Grand Junction.
2. Based on a thorough review of the report by VISN 19 Leadership, I concur with the recommendations and submitted action plans of Western Colorado Health Care System in Grand Junction and VISN 19. As we remain committed to ensuring our Veterans receive exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have questions or additional information is required, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Sunaina Kumar-Giebel, MHA
Director, VA Rocky Mountain Network (10N19)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: February 19, 2025

From: Director, VA Western Colorado Healthcare System (575)

Subj: Healthcare Facility Inspection of the VA Western Colorado Healthcare System in Grand Junction

To: Director, VA Rocky Mountain Network (10N19)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Western Colorado VA Health Care System in Grand Junction, Colorado.
2. I have reviewed the report and concur with all recommendations. Action plans have been developed or implemented and are identified in the Director Comments. I request the closure of recommendation 6.
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 of Quality, Safety, and Value.

(Original signed by:)

Richard W. Salgueiro, FACHE
Executive Director, Western Colorado VA Healthcare System

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.