US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Bronx Healthcare System in New York

Healthcare Facility Inspection	24-00598-91	April 3, 2025

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

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established 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 Bronx Healthcare System (facility) from May 14 through 16, 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. One shock was turnover in executive leadership positions. Two executive leaders had been in their positions since 2022, and another started one month prior to the OIG inspection. Leaders said that staff lacked trust due to previous leaders and therefore met with them more frequently to build trust and implemented tiered huddles and visual communication boards, which increased communication.[2]

Another shock was related to the COVID-19 pandemic, which leaders explained created recruitment and retention challenges for medical professionals. Therefore, leaders introduced special salary rates for radiology professionals, psychologists, and nurses.

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

[2] Tiered huddles are a structured event where leaders and staff share information about current issues, determine the best way to address risks, and discuss lessons learned from previous events. Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

Leaders told the OIG they added administrative staff so clinical staff can spend more time with veterans during appointments, enhanced the main entrance with bright lights and carpeting, and planned to reduce noise levels in inpatient settings to improve veterans' experience at the facility.

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 clear and visible signage directing patients to parking areas, buildings, and the facility's main entrance. The OIG noted that a revolving door at the main entrance was nonfunctional. Leaders said the door frequently breaks down, but they plan to replace it. The OIG also observed dirty floors in the Emergency Department, and stained ceiling tiles leading to the Community Living Center. Because staff corrected these issues during the site visit, the OIG did not make a recommendation.

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 recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found facility staff effectively managed communication of urgent test results to providers through established processes and electronic notifications. The facility had no open recommendations from previous oversight reports. Leaders employed various review processes to identify opportunities for improvement. However, the OIG expressed concerns about the lack of a permanent patient safety manager for nearly a year at the time of the site visit. While the Chief of Quality was acting in the position, one individual filling two major roles that affect patient safety and quality for a prolonged period is unsustainable and could jeopardize quality of care. Because leaders said they were actively recruiting to fill the position, the OIG did not make a recommendation.

Primary Care

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

affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[3]

While leaders did not report shortages of primary care providers, the OIG noted a slight shortage of nursing and administrative staff. Despite the vacancies, veterans did not experience increased appointment wait times or delays in care. To address the shortages, leaders implemented recruitment bonuses in addition to raising pay rates; they also remained focused on maintaining reasonable panel sizes and providing veterans' timely access to care. Staff said they feel supported and encouraged by leaders to implement process improvement initiatives that lead to more efficient and sustainable care.

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 met veterans' needs. The OIG found the facility had effective homeless programs, with a strong emphasis on outreach and collaboration with multiple community partners. Program leaders and staff identified lack of affordable housing as a barrier to meeting veterans' needs. Staff helped veterans apply for Social Security benefits and learn how to create a budget, and a veterans service organization and state representative assisted with veteran benefits.[4]

What the OIG Recommended

Based on this inspection of the five content domains, the OIG has no recommendations.

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

[4] 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.

VA Comments and OIG Response

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

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 Bronx Healthcare System
Bronx, New York
Level 1b-High Complexity
Bronx County
Hospital Referral Region: Bronx

Description of Community

POPULATION

Female **1,238,175**	Male **1,128,769**
Veteran Female **5,252**	Veteran Male **49,642**

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

MEDIAN INCOME

$74,123

EDUCATION

81% Completed High School
63% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **403**

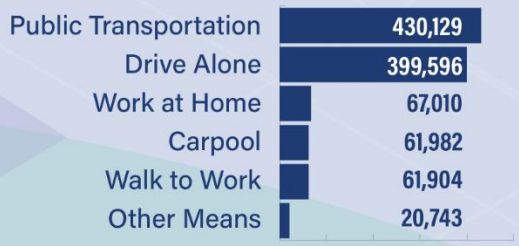
SUBSTANCE USE

18.2% Driving Deaths Involving Alcohol
18.2% Excessive Drinking
1,062 Drug Overdose Deaths

UNEMPLOYMENT RATE

9% Unemployed Rate 16+
7% Veterans Unemployed in Civilian Workforce

TRANSPORTATION



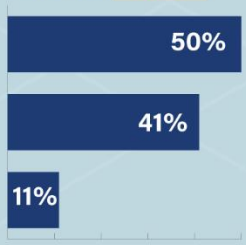
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**10 Minutes, 4 Miles**
Specialty Care	**14 Minutes, 6.5 Miles**
Tertiary Care	**19 Minutes, 11.5 Miles**

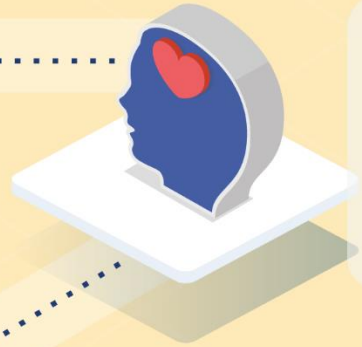
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **11,131**



Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

7,096

158 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.62 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

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

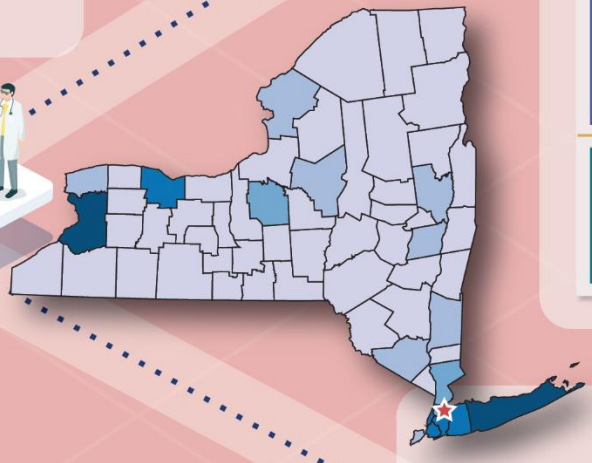
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	25K
Unique Patients VA Care	25K
Unique Patients Non-VA Care	2K

COMMUNITY CARE COSTS

Unique Patient $7,044	Outpatient Visit $454
Line Item $134	Bed Day of Care N/A

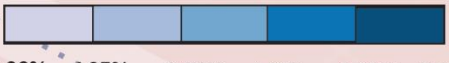


STAFF RETENTION

Onboard Employees Stay <1 Yr	8.85%
Facility Total Loss Rate	15.56%
Facility Retire Rate	3.80%
Facility Quit Rate	9.95%
Facility Termination Rate	1.70%

★ VA MEDICAL CENTER

VETERAN POPULATION



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

Contents

Background and Vision

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

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

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

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

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

High Reliability Organization Framework

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

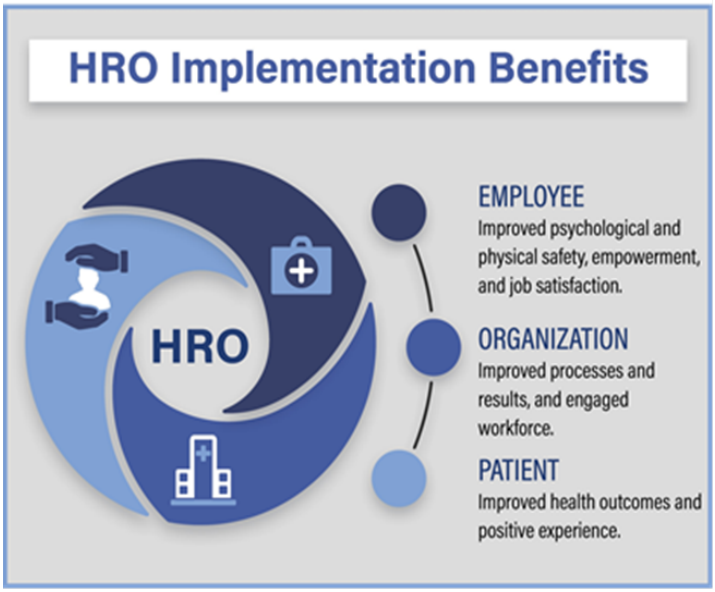


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have

[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, 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.

[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.

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.

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

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

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

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

Content Domains

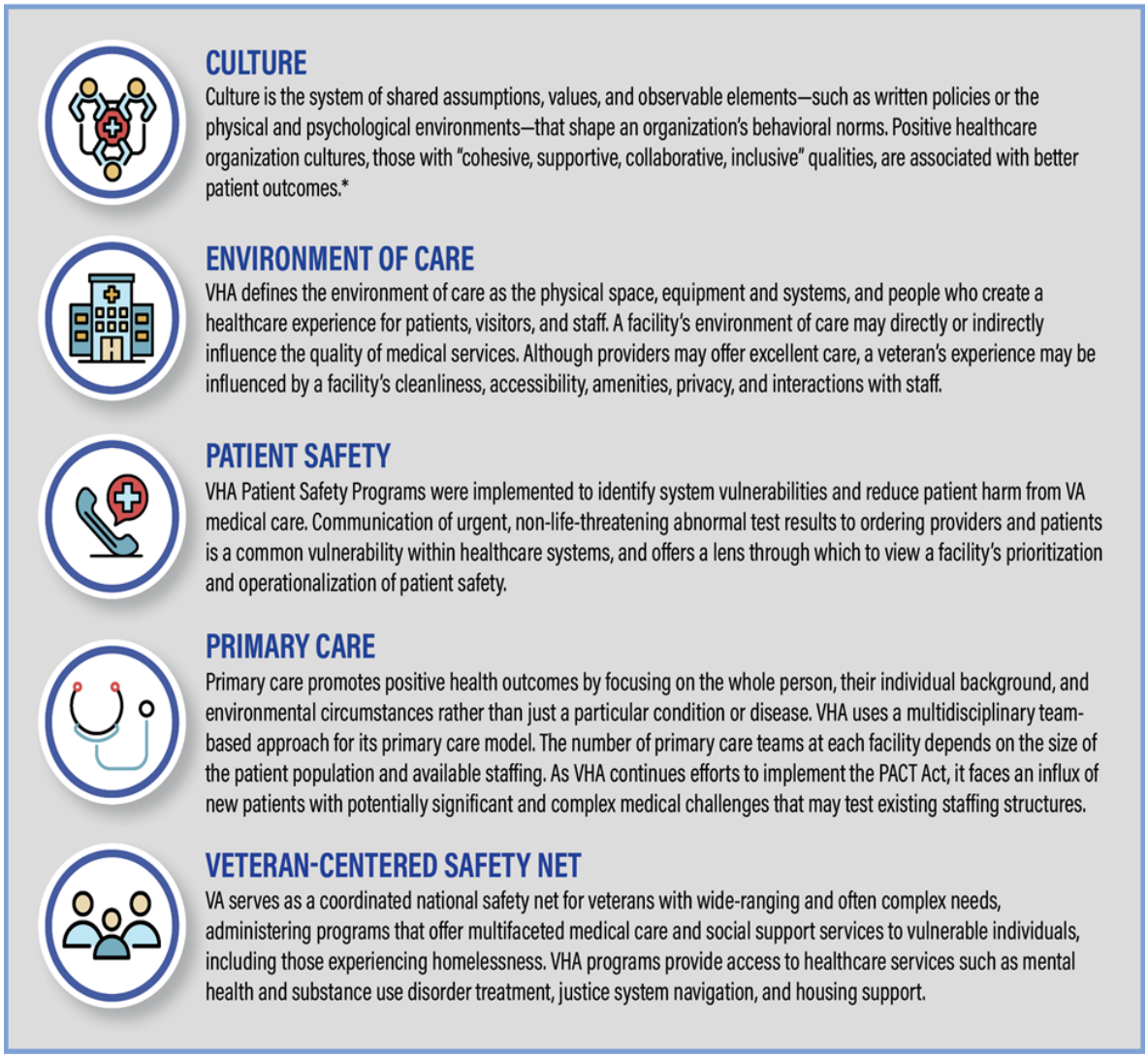


Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; 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 VA Bronx Healthcare System (facility) began providing patient care services in 1923. At the time of the OIG inspection, the facility's executive leaders consisted of a Medical Center Director (Director), Chief of Staff, Associate Director, and Chief Nurse Executive. In fiscal year (FY) 2023, the facility's budget was approximately $481 million. The facility had 311 operating beds (231 hospital and 80 community living center).[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 November 13, 2024. https://www.va.gov/VA_Community_Living_Centers. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 13, 2024, https://www.va.gov/homeless.

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

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

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

System Shocks

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

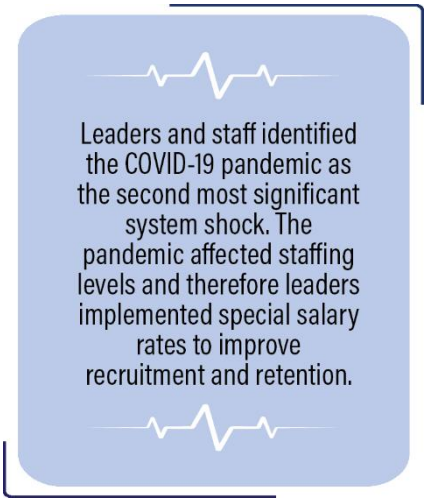


Figure 4. *Facility systems shocks. Source: Leader interviews and staff responses to the OIG questionnaire.*

In interviews, leaders identified two system shocks. The first shock was turnover in executive leadership positions that resulted in three of the four executive leaders being in their positions for less than two years. The Chief of Staff had been in the position since 2020, two other executive team members had started in summer 2022 (Director and Chief Nurse Executive), and one began one month before the OIG inspection (Associate Director). Leaders stated that staff had a lingering distrust from prior leaders. Therefore, they held town hall meetings and visited staff in their work areas to build trust. Leaders also implemented HRO practices, such as tiered huddles and visual communication boards, which they said increased communication between leaders and staff and positively transformed the organization.[19]

The second shock was the COVID-19 pandemic, which affected staffing levels and caused challenges with recruitment and retention of medical professionals. Leaders said they attempted to address the issues by creating special salary rates for radiology professionals, psychologists, and nurses.

[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*.

[19] Tiered huddles are a structured event where leaders and staff share information about current issues, determine the best way to address risks, and discuss lessons learned from previous events. Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

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.

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

The OIG noted that VA survey scores for executive leader communication, transparency, and information sharing had improved from FYs 2021 to 2023. In the OIG's questionnaire, staff responded that leaders' communication was clear, useful, and had improved. Leaders shared several actions they took to improve communication, such as through visits to staff in their work areas, newsletters, and quarterly town hall meetings.

Leaders also explained the intent of messages could be lost as they pass through several leaders, which was a barrier to communication with staff. To overcome this barrier, the Chief Nurse Executive emphasized repeating messages through various methods, like in printed materials and meetings.

[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.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[23] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[24] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

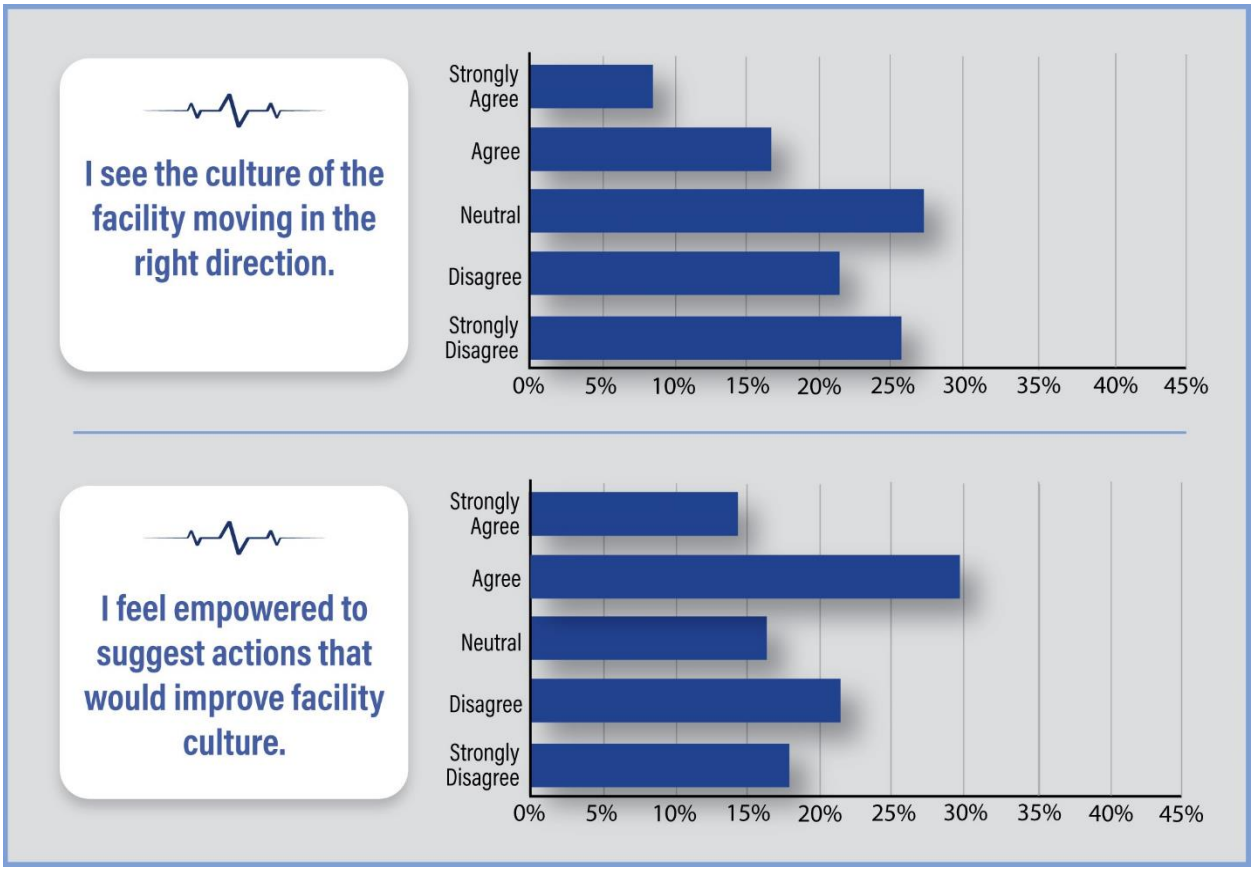


Figure 6. *Employee perceptions of facility culture.*
Source: OIG analysis of questionnaire responses. 256 staff responded to the questionnaire.

[23] "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.

[24] 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 also reviewed VA survey data on employee satisfaction from FYs 2021 to 2023 and found the facility's Best Places to Work score improved to a three-year high in FY 2023. The Director attributed the improvement to leaders' efforts to build trust with employees.

OIG questionnaire data indicated employees felt comfortable reporting patient and safety concerns. During the interview, leaders said that as they walked around the facility, employees became more comfortable with approaching them to report potential safety events, which led to an increased number of Good Catch awards.[25]

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.[26] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[27] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility. Patient advocate responses indicated leaders were responsive to veterans' concerns and effectively addressed their complaints.

The OIG also distributed a questionnaire to local VSOs but did not receive any responses. Despite the lack of responses, the Director said the facility had a strong relationship with VSOs and reported meeting with local and state VSO representatives quarterly at the facility, attending various community events with veterans and VSOs, and creating a community advisory board that includes VSOs. Further, the Director told the OIG that VSOs are welcome to come to the executive office and meet with leaders at any time.

Leaders also told the OIG about steps they had taken to improve veterans' experiences. Specifically, leaders said they added more administrative staff throughout the facility to ensure clerical duties did not fall on clinical staff, which allowed clinical staff to focus more on veterans' care and spend more time with them during their visits. Additionally, the Chief Nurse Executive said the facility had added music, bright lights, and carpeting to the main entrance and planned to reduce the noise level on inpatient floors by connecting televisions to hospital bed speakers. Lastly, leaders shared that a veteran staff member created a wall displaying photographs of veterans, for staff and veterans to view.

---

[25] "The 'Good Catch Award' recognizes employees who report close calls or other patient safety concerns.… This patient safety initiative promotes and encourages transparency by getting direct feedback from frontline staff on how processes can be improved, thereby rendering the safest care possible to our Veterans." "VA Boston Displays Transparency in Patient Safety," Department of Veterans Affairs, accessed February 24, 2025, https://www.patientsafety.va.gov/VA_Boston_Displays_Transparency_in_Patient_Safety.asp.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[28] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[29] 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.[30]

[28] VHA Directive 1608(1).

[29] 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.

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

Transit and Parking

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

The OIG used a navigation link on the facility's website to obtain accurate directions to the facility and followed the directions to the entrance without difficulty. The facility had multiple clear signs directing veterans to parking areas, buildings, and the main entrance.

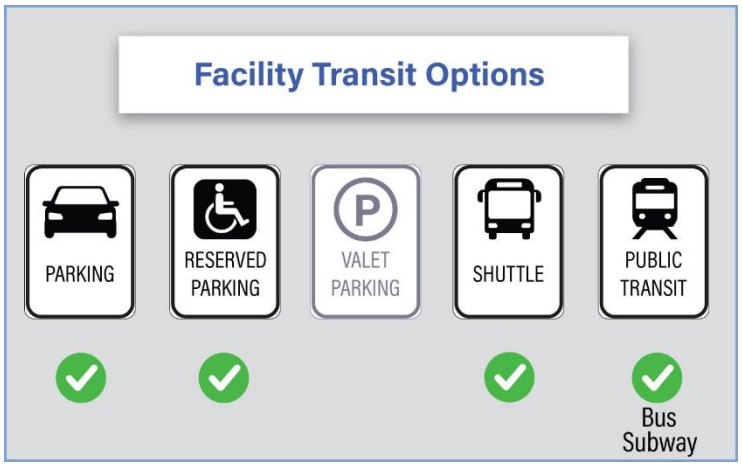


Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

Throughout the inspection week, the OIG observed available parking, with spaces accessible for veterans with disabilities, and multiple bus stops with city buses transporting veterans to the facility. In parking lots, the OIG noted adequate lighting, pathways, and police alarm call buttons for use in emergencies. The facility's transit and parking options were adequate based on the OIG's observations.

Main Entrance

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

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[31]

The facility's designated main entrance had power-assisted doors; however, the exterior revolving door was nonfunctional and remained open throughout the site visit. Facility leaders reported that the revolving door had broken down multiple times in the five months prior to the OIG visit despite frequent maintenance, and they

[31] 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*.

planned to replace it. The entrance also featured an extended roof above the entrance door, offering a sheltered area for veterans. Further, there were smooth transitions from carpet to flooring, which did not pose tripping hazards for veterans with assistive devices. While the main entrance did not have windows, there was sufficient lighting that simulated sunlight. The space was clean and spacious and included a volunteer-staffed information desk, an adjacent café stand, and a few seating areas for veterans to socialize. Additionally, multiple wheelchairs were available at the information desk for veterans needing assistance to reach appointments. The OIG's overall impression was of a clean, functional, and welcoming space.

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.[32]

While no printed maps of the facility were available, the OIG observed directions displayed on large monitors and enclosed display cabinets in the lobby. The OIG noted volunteers assisted veterans mostly by escorting them or providing verbal directions to appointment locations. Additionally, the OIG observed signs within the facility that listed building numbers and service locations. The OIG team easily found locations using these navigational cues.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[33] The OIG noted the patient entrance had detectable changes in

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

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

[33] 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.

flooring and automatic doors.[34] The OIG also observed braille floor numbers outside each elevator, although no further directional information appeared in braille. Additionally, there were no observed audio instructions or cues available for visually impaired veterans. However, the OIG noted that veterans generally did not navigate independently because volunteers helped them.

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.[35]

The facility had two toxic exposure screening navigators, both performing the role as an additional duty. The OIG team interviewed the lead navigator and the backup lead, who described the facility's screening process. The navigators indicated staff screen veterans during primary or specialty care appointments, unscheduled visits with the care team or navigator, and follow-up telephone calls by a licensed independent practitioner or navigator.

The navigators also reported conducting toxic exposure screening outreach events to provide services, information, or resources to veterans in the year prior to the OIG visit. Additionally, the lead navigator reported no access, space, or wait time barriers to 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.[36] 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.

During an interview, the Chief, Engineering Service stated that in FY 2023, the top three deficiencies staff identified during environment of care inspections were problems with floors,

[34] "Detectable warnings are a distinctive surface pattern of domes detectable by cane or underfoot that alert people with vision impairments of their approach to street crossings." "(Proposed) Public Right-of-Way Accessibility Guidelines, Additional Resources, Detectable Warnings Update," Access Board, March 2014, accessed April 3, 2024, https://www.access-board.gov/prowag/other/dw-update.html.

[35] 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.

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

ceilings, and sprinkler heads. The chief discussed a performance improvement plan and future projects to mitigate these issues.

General Inspection

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

The OIG inspected five areas: the Emergency Department, Medical-Surgical unit, Intensive Care Unit, Primary Care Clinic, and Community Living Center. The OIG observed dirty floors in the Emergency Department and stained ceiling tiles in the hallway leading to the Community Living Center. Staff corrected these problems while the OIG was on site. Overall, the OIG found the facility clean and well maintained. There were clear exit paths, patients were able to move freely, and no protected patient information was visible.

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.[37] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[38] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG found the facility had processes and procedures that established staff responsibility to notify the ordering provider of test results and for the ordering provider or designee to communicate test results to patients. Additionally, the facility had a system to identify a backup

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

[38] 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.

provider when the ordering provider was unavailable. Providers also had a process to indicate which abnormal test results required follow-up. Facility leaders and quality management staff expressed their commitment to monitoring their performance closely and promptly addressing any issues. To demonstrate this commitment, leaders stated that if a provider did not communicate test results to patients within the required time frame, a multidisciplinary team re-educated the provider on VHA's expectations.[39]

VHA outlines a method for the communication of test results to providers through alerts in the electronic health record.[40] A high volume of alerts could lead to alert fatigue, which occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings."[41] Facility leaders acknowledged the challenge of alert fatigue and said they review the volume and response times of unanswered alerts daily to identify patterns and improve overall efficiency in providers communicating test results to patients.

Action Plan Implementation and Sustainability

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

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[42] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG did not find any open recommendations from the previous three years. During discussions with facility leaders and quality management staff, the OIG learned the facility's quality management process involved collaboration across departments to ensure staff continued to implement action items for compliance with prior recommendations. Quality management staff monitored compliance and reported monthly to the Acute Care Council. However, the OIG discovered the facility had been without a permanent patient safety manager for nearly a year. According to facility leaders, the Chief of Quality was filling the role, but having one individual perform two major roles for a prolonged period is unsustainable and could increase the risk of

[39] VHA Directive 1088(1).
[40] VHA Directive 1088(1).
[41] "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.
[42] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

missing important safety issues. However, since leaders were recruiting to fill the position at the time of the site visit, the OIG did not make a recommendation.

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.[43] 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.[44] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In a recent improvement project to minimize the risk of alert fatigue, the Clinical Applications Informatics team identified 78 view alerts that could potentially be removed. According to leaders, they established a multidisciplinary team to review the alerts, and based on their expertise, the team recommended to remove 49 of them. Leaders said they will gather data to determine if actions taken reduce the risk of alert fatigue.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[45] 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.[46] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

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

[44] VHA Directive 1050.01(1).

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

[46] 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.[47] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG visit, the facility did not have any shortages of primary care providers. Although the primary care clinics had a slight shortage of nursing and administrative staff, a leader told the OIG that patients did not experience increased appointment wait times or delays in care. While staffing shortages were minimal, leaders conveyed that certain nursing positions (such as for licensed practical nurses) were experiencing nationwide shortages, which caused the facility to compete with other healthcare facilities for staffing. To address these challenges, leaders implemented a recruitment bonus and increased salaries, ultimately reducing overall nursing vacancies.

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

Primary care staff reported that panel sizes and coverage expectations were reasonable given current staffing levels. Primary care staff also said work assignments were well balanced, primarily due to the recent primary care team consolidation project as discussed in the PACT Act and Primary Care section below. The Facility Coordinator for Primary Care Management Module reported meeting weekly with primary care leaders to review team capacity; assign new patients to teams; and discuss staffing, leave and coverage, and scheduling modifications. The OIG found the average wait time for primary care appointments was 5 days for new patients and 12 days for established patients, which are both below VHA's goal of 20 days.[50]

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[51] Continuous process improvement is also one of the three

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

[48] "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).

[49] VHA Directive 1406(1).

[50] VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024; Assistant Under Secretary for Health, Office of Integrated Veteran Care (IVC), "Veteran Appointment Scheduling and Community Care Wait Time Eligibility (VIEWS # 08891707)," memorandum to Veterans Integrated Service Network (VISN) Directors, Medical Center Directors, November 18, 2022.

[51] VHA Handbook 1101.10(2).

HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

In an interview, primary care staff said they meet with primary care leaders to discuss opportunities for improvement during daily team huddles, monthly staff meetings, and leaders' visits to the work area. Staff added they feel supported and encouraged by leaders to present best practices and process improvement projects in various forums. Staff also shared examples of nurse-driven initiatives, including a multidisciplinary project aimed at improving patient awareness and adherence to recommended treatments for hypertension and diabetes. As part of the initiative, dietitians educate patients about nutrition, nurses teach patients how to monitor their blood pressure, pharmacists adjust medications, and administrative staff schedule patients for lab tests to assess blood sugar control. These efforts led to care that was more efficient, sustainable, and well received by patients.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The facility had experienced a decrease in veteran enrollment in the three years prior to the OIG site visit, which leaders attributed to the COVID-19 pandemic and the decreasing veteran population in urban areas. In anticipation of an enrollment increase, facility leaders collaborated with primary care staff to launch a project consolidating specialty care and primary care teams. The project successfully reduced the number of specialty and primary care teams from 53 to 30, stabilized workloads, and minimized referrals to care in the community. Primary care team members stated the addition of toxic exposure screenings did not negatively affect their functioning.

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

Health Care for Homeless Veterans

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

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[52]

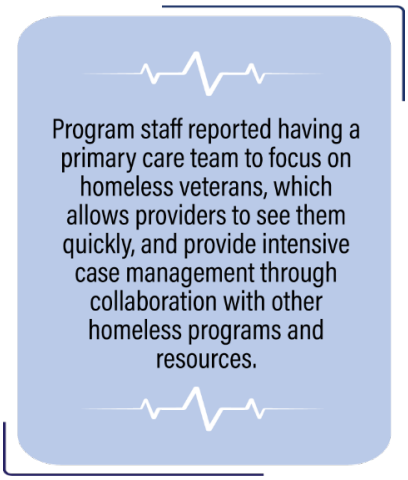


Figure 12. *Primary care team focus on homeless veterans.*
Source: OIG interview with program staff.

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).[53] 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."[54]

In FY 2023, VHA exempted the facility from the HCHV5 performance measure because the total number of unsheltered veterans in the facility's service area was too small to meet the target. The Community Support Services Manager informed the OIG that the point-in-time count was a well-organized effort in New York City that accurately captured the number of homeless individuals on a specific night each year.

The manager said that referrals to the program came from a variety of sources, including the National Call Center for Homeless Veterans, New York City outreach program staff, and facility mental health and primary care staff. The manager explained that city and state policies affected the number of veterans within shelters. The manager told the OIG that New York is one of only a few "right to shelter" states, which leads to many veterans seeking shelter in the facility's service area.[55] Additionally, New York City has laws that allow police to take an individual to a shelter when the temperature is below 32 degrees.

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

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

[54] 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.

[55] New Yorks City's right to shelter is defined as follows: "Anyone in need of a bed, including asylum seekers, is entitled to one…asylum seekers will retain the ability to enter the Department of Homeless Services shelter system at any time." "Joint Statement from Legal Aid, Coalition for the Homeless on Mayor Adams' Comments on Asylum Seekers and New York's Right to Shelter," Coalition for the Homeless, accessed June 3, 2024, https://www.coalitionforthehomeless.org/press/joint-statement.

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).[56]

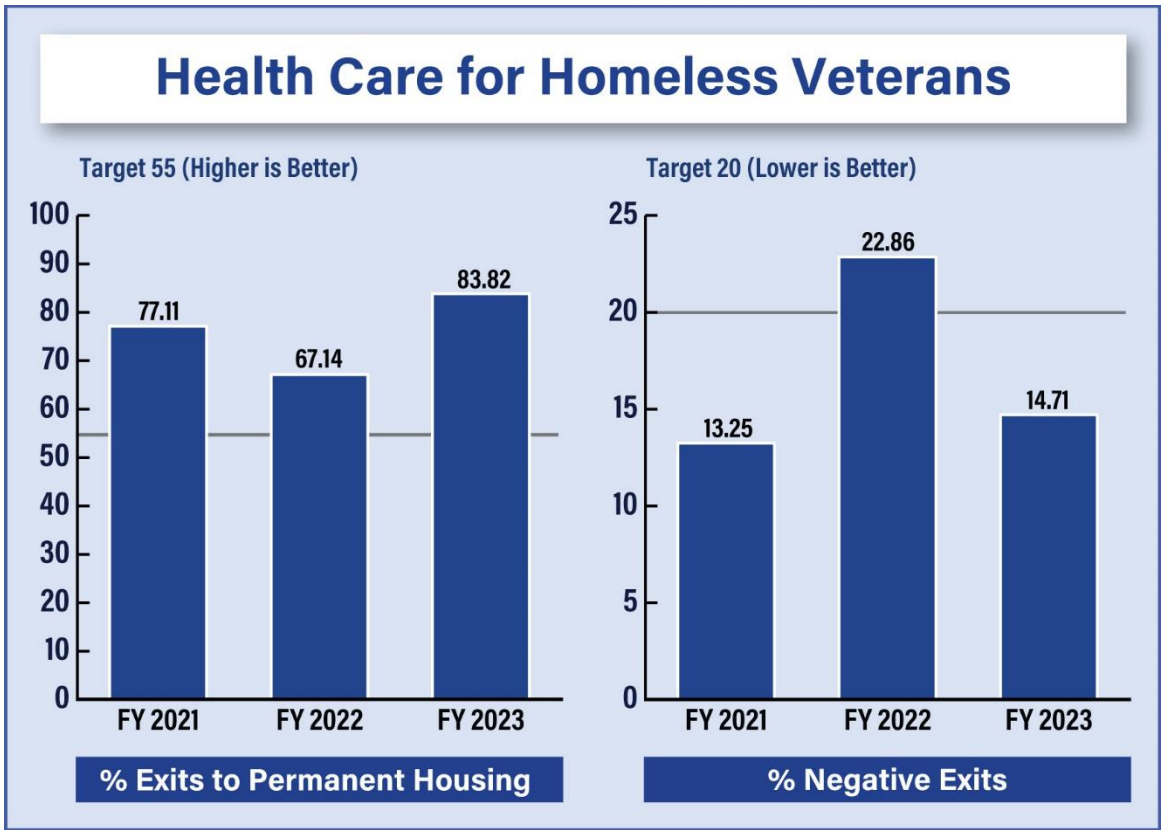


Figure 13. *HCHV program performance measures.*
Source: OIG analysis of VHA Homeless Performance Measures data.

The facility met the FY 2023 targets for HCHV1 and HCHV2. In an interview, the Chief of Social Work highlighted their success in rapidly engaging with homeless veterans, connecting them with community resources, and sheltering them through a low-demand safe haven shelter.[57]

[56] 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*.

[57] "The low-demand or non-intrusive environment is designed to establish trust and motivate homeless Veterans to seek needed treatment services and transitional and permanent housing options," VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program,* February 22, 2022. "[Low-Demand Safe Haven] programs are designed to provide low-demand housing services to Veterans as they transition to other programs or to PH [permanent housing]." VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

The shelter had fewer imposed requirements than traditional shelters, such as allowing veterans to stay in the shelter despite having untreated mental illness and substance use issues and not imposing a curfew.

Further, the Community Support Services Manager said they identified needs of homeless veterans by fostering strong relationships with community partners. LegalHealth, for instance, offered free legal advice to low-income veterans and worked to address the increasing number of veterans facing evictions following the pandemic.[58]

Program staff reported a major barrier to meeting veterans' needs as lack of affordable housing. The Community Support Services Manager described approaches to assisting veterans with financial constraints to improve access to available housing. For example, staff have specialized training to help veterans apply for Social Security benefits and maximize income through budget planning. In addition, the facility had an on-site VSO and New York state representative available to assist homeless veterans with issues like veteran benefit claims.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[59] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[60]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[61] The program met the performance measure target for FY 2023. The Veterans Justice Coordinator described their role to identify veterans who are eligible to participate in the program and assist with transferring them from the criminal court system to the veterans treatment court whenever possible.[62] In addition, the coordinator educates all facility

[58] "LegalHealth, a division of NYLAG (New York Legal Assistance Group), provides free legal assistance to New Yorkers who are experiencing serious or chronic health problems and financial hardship." "Complementing Healthcare with Legal Care," LegalHealth, accessed August 23, 2024, https://legalhealth.org/.

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

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

[61] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[62] A Veterans Treatment Court "is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs,* April 4, 2024.

employees at new employee orientation; and jail staff, community providers and agencies, and the county's domestic violence department court staff about the program.

Meeting Veteran Needs

The Veterans Justice Outreach Coordinator reported establishing positive relationships with criminal justice system and jail staff. The coordinator emphasized participating in weekly court case conferences with the judge and district attorney staff to advocate for appropriate and available treatment options for veterans. The Community Support Services Manager described the facility's deflection program as a collaborative effort for VA staff and local law enforcement to identify veterans with a past criminal behavior or those at risk of arrest and connect them with supportive VA healthcare services to address underlying behavioral health issues.[63]

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."[64] 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.[65]

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).[66] The OIG found that the facility met the performance measure target for FYs 2021 through 2023.

---

[63] The Model Law Enforcement and Other first Responder Deflection Act provided a legislative framework for deflection programs. "The purpose of this Act is to encourage the development and use of deflection programs throughout a state to unite law enforcement, substance use disorder and mental health providers, and other community providers in the shared goal of deflecting individuals away from traditional criminal justice processing, thereby providing the opportunity to better address the needs of individuals living with substance use disorder, mental health disorder, or co-occurring disorders." Legislative Analysis and Public Policy Association, *Model Law Enforcement and Other first Responder Deflection Act*, September 2021, https://legislativeanalysis.org/Model-Law-Enforcement-and-Other-First-Responder-Deflection-Act.pdf.

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

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

[66] VHA sets the HMLS3 target at the national level each year. The FY 2021 and FY 2022 target was 92 percent or above. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

The facility served a large service area, including five boroughs of New York City and lower Westchester County, New York. A Housing and Urban Development–Veterans Affairs Supportive Housing Coordinator described collaborative relationships with the three housing authorities in the service area.

The Community Support Services Manager indicated that the program's major challenge was 11 position vacancies, including a key contracting officer position. According to a program coordinator, the vacancies contributed to delays in admitting veterans to the program. The manager described leveraging a contract that would provide additional staff to manage 150 vouchers and case management services; however, the key contracting officer position to oversee this contract was vacant. In addition, the manager secured retention bonuses to retain existing staff.

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).[67] The facility did not meet the target in FY 2023; however, performance improved compared to the previous FY.[68] The Community Support Services Manager and Housing and Urban Development–Veterans Affairs Supportive Housing coordinators attributed missing the target to a high percentage of the facility's veteran population lacking consistent and continuous employment due to mental health and substance abuse issues. In an interview, the manager reported that the program's Employment Coordinator organized events, assessed veterans' employment interests, and aligned appropriate job opportunities to eligible veterans.

The manager and coordinators told the OIG that some homeless veterans who refused to come to the facility or suffered from substance abuse or psychiatric issues did not engage in the program. To address this issue, the coordinators described a pilot program initiated the previous year that involved program therapists who provide mental health and other services, such as family and cognitive assessments and long- and short-term interventions, in shelters and veterans' homes. However, the coordinators indicated staff had not yet assessed the pilot program's effectiveness.

[67] 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*.

[68] The facility's VASH3 scores were 27.24 percent in FY 2022 and 41.04 percent in FY 2023.

Conclusion

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

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to five VSOs; however, none of the VSOs responded. 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.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] 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 14 through 16, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in March 2024. The previous Comprehensive Healthcare Inspection Program report was issued on March 3, 2022.

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

[3] 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.[4] 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.

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 19, 2025

From: Director, New York/New Jersey VA Health Care Network (10N2)

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

To: Director, Office of Healthcare Inspections (54HF01)

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

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

I concur with your assessment of the findings and appreciate that there were no recommendations for the VA Bronx Healthcare System. VA Bronx (James J. Peters VA Medical Center) and the entire VISN 2 Network remains committed to continuous improvement and the welfare of our Veterans.

(Original signed by:)

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

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: March 18, 2025

From: Medical Center Director, VA Bronx Healthcare System (526)

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

To: Network Director, New York/New Jersey VA Health Care Network (10N2)

We have received and reviewed the OIG Healthcare Facility Inspection draft report for the VA Bronx Healthcare System (James J. Peters VA Medical Center) related to the Healthcare Facility Inspection from May 14th through 16th, 2024.

In this draft report, the OIG made no recommendations for improvement.

The James J. Peters VA Medical Center remains committed to continuously improving the quality and safety of Veterans in our care.

(Original signed by:)

Balavenkatesh Kanna, MD, MPH
Medical Center Director
James J. Peters VA Medical Center

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Elisa Gomez, MSN, RN, Team Leader Mark Bartuska, MHA, RN Edna Davis, BSN, RN Karla Kisiel, MSN, RN Simonette Reyes, BSN, RN
Other Contributors	Kevin Arnhold, FACHE Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Scott McGrath, BS Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dave Vibe, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 2: New York/New Jersey VA Health Care Network
Director, VA Bronx Healthcare System (526)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Kirsten Gillibrand, Chuck Schumer
US House of Representatives: Yvette Clarke, Adriano Espaillat, Dan Goldman, Hakeem Jeffries, George Latimer, Mike Lawler, Grace Meng, Gregory Meeks, Jerry Nadler, Alexandria Ocasio-Cortez, Ritchie Torres, Nydia Velazquez

OIG reports are available at www.vaoig.gov.

Pursuant to Pub. L. 117-263, section 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.