US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee

Healthcare Facility Inspection	24-00611-82	April 1, 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 Memphis Healthcare System (facility) from May 20 through 23, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

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. Results from the OIG's facility-wide questionnaire showed respondents identified the most prevalent system shock as turnover in key leadership positions. The associate director for patient care services position was filled with acting staff for two years prior to the permanent associate director's appointment. To ensure a successful transition, the Director reported arranging mentorships, consulting with a national program office, and making sure other executive leaders assisted the new associate director.

Leaders discussed other system shocks as high local crime rates, inclement weather, and city water infrastructure issues. Leaders explained that crime rates created challenges with staff recruitment and discouraged a community organization's willingness to volunteer at the facility. The Chief of Police enacted safety measures, such as increasing the number of contracted security personnel patrolling the facility parking lots and procuring a new weapons detection system. Leaders also said inclement weather caused closures at community-based outpatient

[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.

clinics, and city water infrastructure issues resulted in occasional notices to boil water, which disrupted services at the facility.

The Director explained the realignment of human resources functions from the facility to the Veterans Integrated Service Network was a system shock because it delayed onboarding of new staff and posting position vacancies and added human resource responsibilities to the duties of hiring managers, such as surgeons.[2] The Director said a final system shock occurred in December 2023 when the Veterans Integrated Service Network notified leaders of a reduced full-time staffing limit. The Director added the revised staffing limit was less than the prior threshold. However, to ensure patients continued to receive adequate care, the Director reported instructing staff to continue onboarding new hires with firm offers.

The OIG's facility-wide questionnaire indicated that staff, in general, believed leaders' communication was clear and useful. In addition, most staff felt comfortable suggesting actions to improve their work environment. The leaders described efforts to improve communication among nurses and throughout the facility.

Based on responses from the veterans service organization questionnaires, the most common complaints from veterans involved parking, crime in the facility's local area, and unanswered telephone calls.[3] The Director stated the Chief of Police attended a town hall with veterans service organization representatives to provide information on actions taken to improve safety and security at the facility. In addition, the Director explained a telephone coordinator had been helpful in conveying the facility's needs to the Office of Information Technology and ensuring staff met leaders' call management expectations.

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. In general, the facility appeared clean and well maintained, but the OIG made recommendations in several areas.

[2] Beginning in fiscal years 2019 and 2020, and due to a national human resources staffing shortage, VHA centralized human resources functions from the facilities to the Veterans Integrated Service Networks (VISNs) with the intent to standardize processes and make this function more effective. "VISN Human Resources Realignment Talking Points," Department of Veterans Affairs, accessed April 10, 2024, https://dvagov.sharepoint.com/HR-Modernization. (This website is not publicly accessible.) 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/.

[3] Veterans service organizations advocate for veterans and help "with applications for veterans benefits and appeals." "Veteran Community Support and Information, Veteran Service Organizations," Department of Defense, assessed January 16, 2025, https://www.defense.gov/Contact/Help-Center/Article.

The OIG found crosswalks had faded or worn markings and lacked signs or a warning system. The bed tower entrance consisted of an inoperable revolving door and two power-assisted doors with a small pathway in between; neither door had a sensor to delay closure when someone was in the doorway, which created an injury hazard. In addition, the inoperable revolving door had inadequate warning signs.[4] An emergency exit near the laboratory was locked and had a large sign blocking the doors, creating a barrier to exiting the area in case of an emergency.

Additionally, the OIG found the spinal cord injury building lacked auditory cues and tactile signs (braille) to assist vision impaired veterans. The OIG also noted televisions in public areas did not have closed captioning on to accommodate those with hearing impairments.

The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act expanded VA health care to veterans exposed to toxic substances.[5] The OIG found staff had not completed more than 300 toxic exposure screenings. The toxic exposure screening navigator attributed it to not having a provider available to complete them. The OIG made a recommendation for leaders to address this deficiency.

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. A recently published OIG hotline healthcare inspection report made five recommendations, which were still open at the time of the OIG's site visit.[6] The OIG also identified two open recommendations from a prior VA National Surgery Office site visit. Facility leaders supplied updated action plans with revised target dates.

The Chief of Quality, Safety, and Value said workgroups address patient safety trends identified from oversight reports. The chief also highlighted the monthly patient safety forum to communicate with staff in an interactive and engaging manner, so they learn about process improvements.

Primary Care

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

[4] Additional photos of the facility related to the environment of care are found in appendix C.

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

[6] VA OIG, *Care Deficiencies and Leaders' Inadequate Reviews of a Patient Who Died at the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee*, Report No. 23-00777-52, January 10, 2024.

PACT Act and new patient appointment wait times.[7] The OIG found the PACT Act had not increased veteran enrollment and instead, it decreased from fiscal year 2021 to August 2023.

The OIG found no shortages in primary care provider, registered nurse, or licensed practical nurse staffing, although there was a shortage of medical support assistants. The Chief, Business office explained that to address the shortage, the assistants cover more than one team. The Director further explained that recruitment for medical support assistants was difficult due to the low starting pay and a lengthy hiring process.

Staff expressed concern about the high volume of electronic health record system view alerts being a major issue that negatively affected clinical work process efficiency. The Chief of Health Informatics mentioned providing leaders with a report of unaddressed view alerts each week. The Associate Chief of Staff for Ambulatory Care highlighted using the report to identify providers who had a high volume of unaddressed alerts and educating them on how to better manage the notifications.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. Program staff described barriers to enrolling veterans in the programs, such as limited staffing and drug activity in the Memphis area that likely deterred veterans from traveling to the facility to receive services. Therefore, for veterans who do not want to come to the Memphis area, staff work with community partners to help them find shelter and other resources. Staff also held community meetings in which veterans could discuss eligible benefits with a VA representative, housing vouchers with program staff, and employment opportunities with a vocational specialist.

What the OIG Recommended

The OIG made five recommendations for improvement.

1. Facility leaders improve crosswalk visibility and monitor pedestrian safety between the parking garage and bed tower entrance until completion.
2. Facility leaders improve doorway safety at the bed tower entrance by placing sensors on the two power-assisted doors, reactivating the revolving door, and monitoring doorway safety until completion.
3. The Director ensures staff monitor the emergency exit near the laboratory to make sure the door remains unlocked and operational.

[7] PACT Act.

4. The Director assesses the facility's tactile signs (braille) and auditory cues and implements a plan to address the deficient areas.
5. Facility leaders evaluate the toxic exposure screening process and implement a plan to ensure staff complete the screenings.

VA Comments and OIG Response

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

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
QSV	Quality, Safety, and Value
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Memphis Healthcare System
Memphis, Tennessee
Level 1a-High Complexity
Shelby County
Hospital Referral Region: Memphis

Description of Community

POPULATION

Female **1,169,321**	Male **1,090,911**
Veteran Female **14,457**	Veteran Male **110,686**

Homeless - State **10,567**
Homeless Veteran -State **549**

MEDIAN INCOME

$43,742

EDUCATION

81% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **446**

SUBSTANCE USE

23.2% Driving Deaths Involving Alcohol
14.1% Excessive Drinking
883 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	815,298
Carpool	90,344
Work at Home	36,563
Walk to Work	10,692
Other Means	10,605
Public Transportation	4,973

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**34 Minutes, 31 Miles**
Specialty Care	**83 Minutes, 79 Miles**
Tertiary Care	**84 Minutes, 81 Miles**

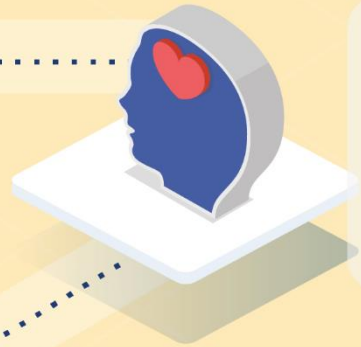
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **35,232**

Veterans Receiving Teleheath (Facility)	57%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	16%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

13,424

257 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.10 Days

30-DAY READMISSION RATE

12%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
22	39

Health of the Facility

UNIQUE PATIENTS

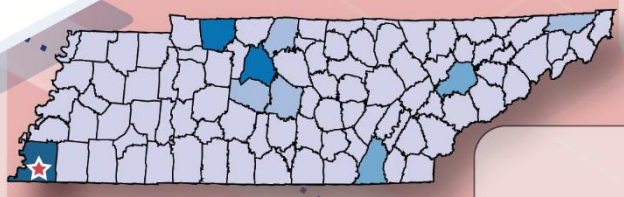
Unique Patients VA and Non-VA Care	70K
Unique Patients VA Care	66K
Unique Patients Non-VA Care	25K

COMMUNITY CARE COSTS

Unique Patient	$23,490
Outpatient Visit	$298
Line Item	$681
Bed Day of Care	$350

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.90%
Facility Total Loss Rate	12.82%
Facility Retire Rate	3.05%
Facility Quit Rate	8.59%
Facility Termination Rate	0.94%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.07% 2.43% 4.79% 7.15% 9.51% 11.86%

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

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

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

High Reliability Organization Framework

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

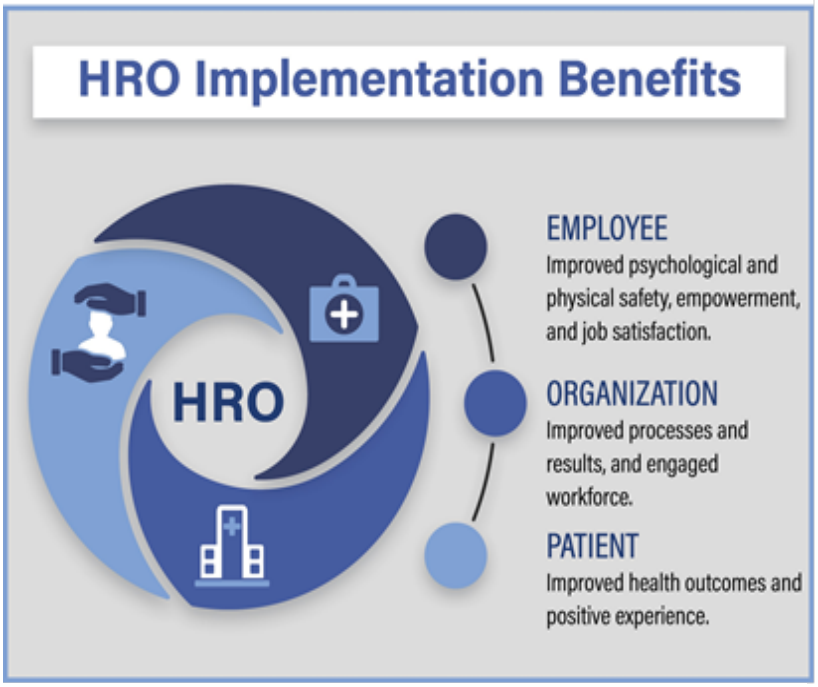


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

[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.

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

PACT Act

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

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

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

[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).

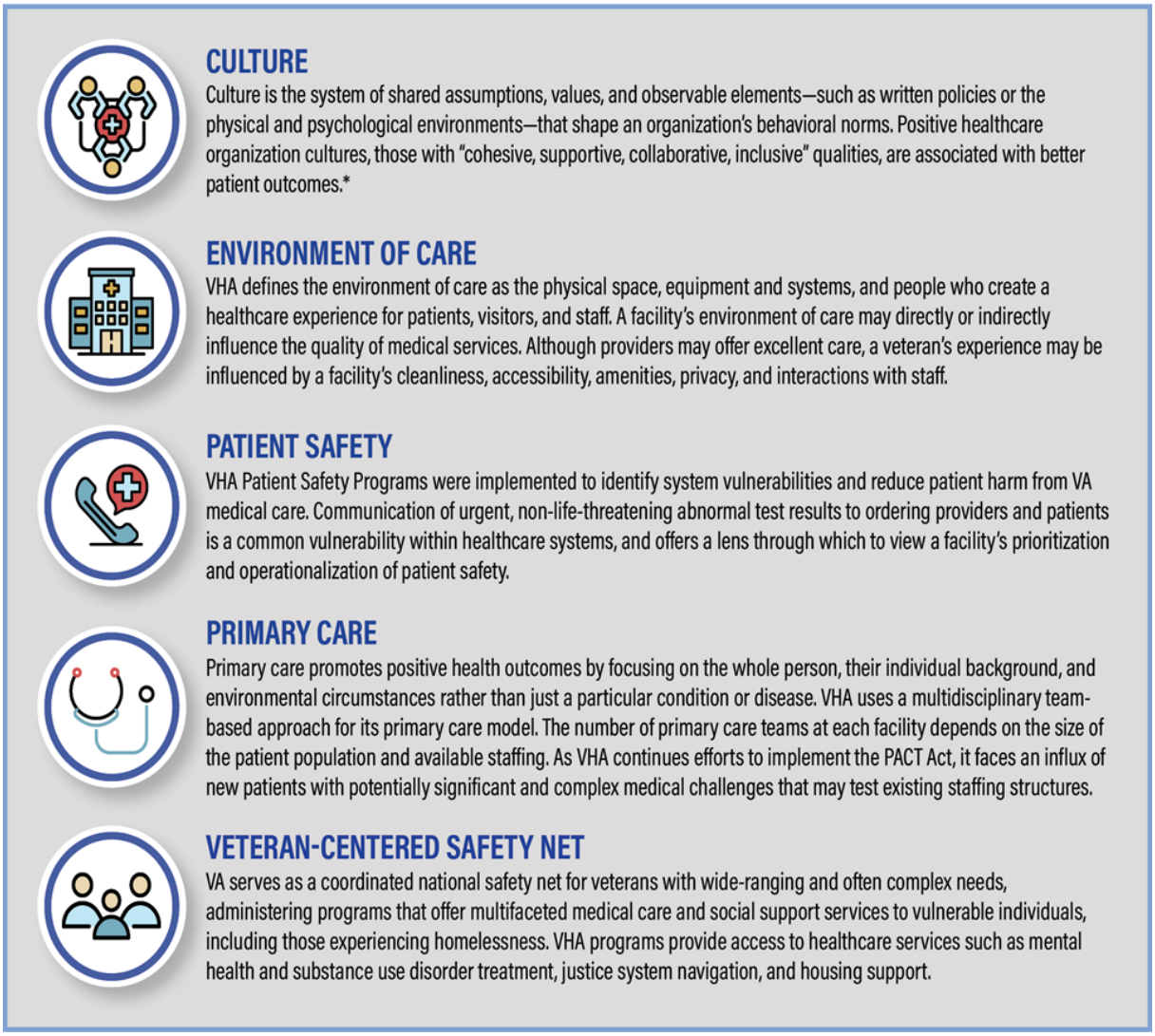


Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight 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 Lt. Col. Luke Weathers, Jr. VA Medical Center of the VA Memphis Healthcare System (facility) opened in 1922 and its service area covers western Tennessee, northern Mississippi, and northwestern Arkansas.[13] A facility staff member said that at the time of the OIG inspection, executive leaders consisted of a Director, Chief of Staff, Deputy Chief of Staff, Associate Director for Patient Care Services (ADPCS), Deputy ADPCS, Associate Director, and Assistant Director. The newest member of the leadership team, the Deputy ADPCS, was assigned in June 2022, and the most tenured, the Chief of Staff, was assigned in March 2017. In fiscal year (FY) 2023, the facility's budget was approximately $600 million. The facility had 159 operating beds, which included 143 hospital and 16 domiciliary beds.[14]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

[13] "VA Memphis Health Care, About Us," Department of Veterans Affairs, accessed January 15, 2025, https://www.va.gov/memphis-health-care/about-us/.

[14] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed January 15, 2025, https://www.va.gov/homeless/dchv.

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

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

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

System Shocks

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

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

The OIG's questionnaire indicated respondents generally believed the most prevalent system shock was turnover in key leadership positions. For example, the ADPCS reported the position was filled with acting staff for two years prior to being permanently appointed. To assist the ADPCS and minimize this system shock, the Director described facilitating mentorships from seasoned nursing leaders at other medical centers, consulting with a national program office, and ensuring other executive leaders provided support.

The executive leaders also identified some short-term system shocks, including inclement winter weather that forced community-based outpatient clinics to close, and city water infrastructure failures that resulted in an occasional notice to boil water, which disrupted service at the facility. The Director reported other system shocks were related to high local crime rates that negatively affected staff recruitment. One VSO leader shared that the local crime rate also discouraged members from a community organization from volunteering at the facility. Because of the area's crime rate, the Director reported using special authorized recruitment incentives to hire staff.

The Director reported reviewing various reports listing Memphis among the top ten US cities for high crime rates in several categories. The Chief of Police added that theft of personal property was the most common crime reported at the facility. The chief also said the facility had a functional yet outdated video surveillance system and multiple issues with contracted security companies that created challenges in ensuring a safe and secure environment. The chief

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

[19] 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.*

explained there were limited contracted security companies in the area, so they worked with the current company to remove security staff who were sleeping while on duty and assisting with vehicle break-ins and thefts. To increase staff and visitor safety, the chief reported taking steps like increasing the number of contracted security personnel who patrol the parking lots, checking the identification of individuals who enter the medical center campus, procuring a new weapons detection system, minimizing the number of access points to enter the facility, escorting staff to and from their vehicles, and training staff on personal safety.

The Director further explained how the realignment of human resources functions from the facility to the Veterans Integrated Service Network (VISN) was a system shock.[20] The Director said the realignment was problematic and that, after the centralization of human resources staff, there was a lack of accountability to facility leaders and delayed onboarding of new staff. The executive leaders detailed difficulties with human resources staff approving position descriptions, which delayed them in advertising open positions.[21] The Chief of Staff added the inefficiencies led to hiring managers, such as surgeons, taking on responsibilities of the human resources specialist in addition to their normal duties.

Lastly, the Director said the facility experienced a system shock in December 2023 when the VISN Director notified facility leaders of a revised staffing ceiling (limit on the number of full-time staff). The Director said the ceiling was reduced, but leaders initially continued to hire individuals who had already received a firm offer while they established a plan to address the change.

[20] Beginning in FYs 2019 and 2020, and due to a national human resources staffing shortage, VHA centralized human resources functions from the facilities to the Veteran Integrated Service Networks (VISNs) with the intent to standardize processes and make this function more effective. "VISN Human Resources Realignment Talking Points," Department of Veterans Affairs, accessed April 10, 2024, https://dvagov.sharepoint.com/HR-Modernization. (This website is not publicly accessible.) 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/.

[21] "A position description or 'PD' is a statement of the major duties, responsibilities, and supervisory relationships of a position." "General Questions and Answers," Office of Personnel Management, accessed September 3, 2024, https://www.opm.gov/frequently-asked-questions/what-is-a-position-description.

Leadership Communication

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

EXECUTIVE LEADER COMMUNICATION
The Chief of Staff said service chiefs visit community-based outpatient clinics to ensure organizational alignment and communication. Service chiefs are encouraged to spend the day with staff and to assess veterans' experiences for improvement opportunities.

EXECUTIVE LEADER INFORMATION SHARING
The Director described an employee recognition program that includes lunch with the Director as a method to share information.

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

The OIG also reviewed the facility-wide questionnaire, which indicated that overall, staff perceived leaders' communication to be clear and useful. During an interview, the ADPCS described initiating nursing-specific town halls to share information and facilitate communication with staff on all shifts. The ADPCS added that feedback from staff indicated an appreciation for the increased visibility of different nursing leaders. The Director discussed using a combination of efforts to improve communication with staff, such as

- weekly emails,
- executive leader rounds (visits to staff at their work locations) to discuss concerns or answer questions,
- an employee suggestion box, and
- open-door policies among facility leaders.

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

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

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

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

During leaders' rounds, they found that Intensive Care Unit nursing staff shared computers on wheels because several were inoperable; leaders placed priority work orders and they were repaired. According to the Director, the goal of these measures was to remove roadblocks to staff providing patient care and to improve their work experiences.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[26] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[27]

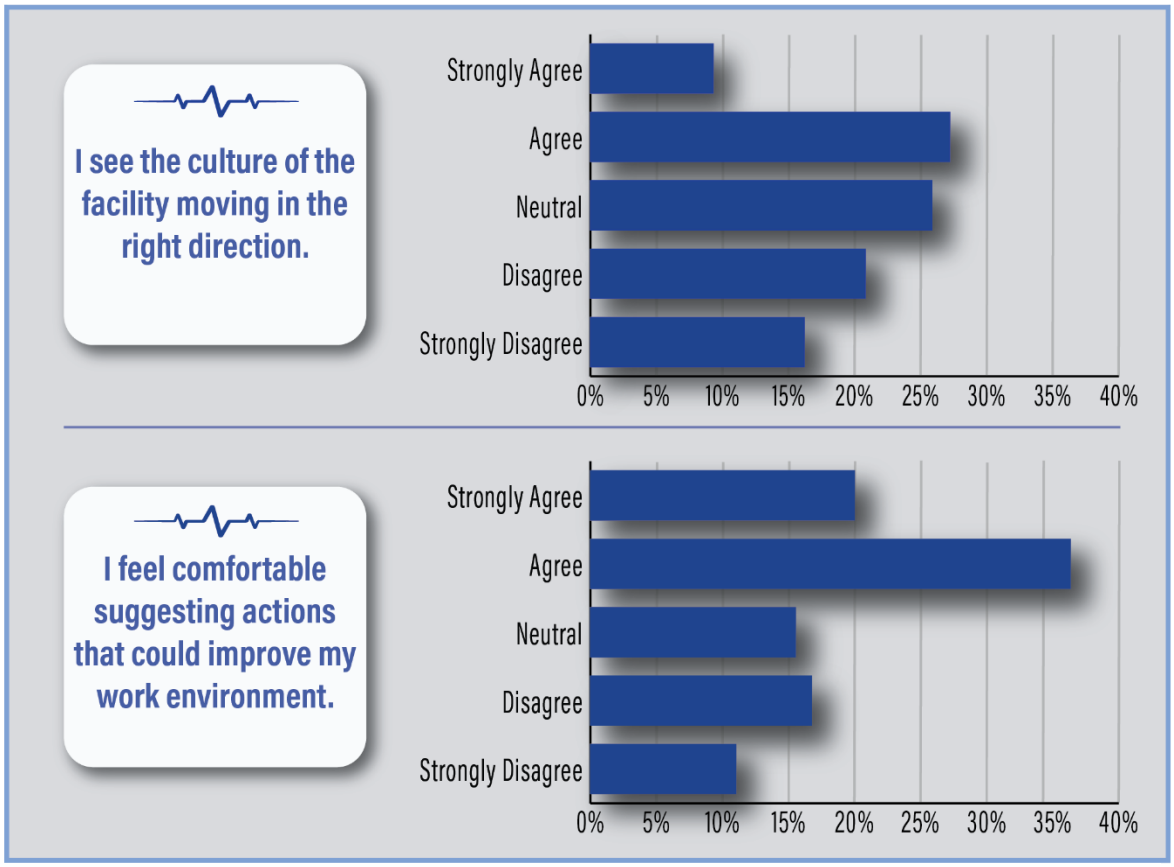


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

[26] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[27] 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.

Responses showed employees generally felt comfortable suggesting actions to improve the work environment, yet a slight majority disagreed the culture was moving in the right direction. The Chief of Staff attributed employees' opinions regarding facility culture to the belief that clinical employees had to work harder because of increased responsibilities and reduced resources. Executive leaders explained that, while various efforts to improve employee well-being had helped positively steer facility culture, the previously discussed system shocks may have affected their perceptions of improvements.

The Director described focusing on employees' physical safety, recognition, accountability, and workload to improve their experience at the facility. For example, 300 facility employees had participated in a VHA pilot project in which they received one protected self-care hour in the day to use for activities such as yoga, meditation, and time away from their workspace. The Director also reported initiating time-in-service awards and other employee recognition programs within the past two years.

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.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

VSO questionnaire respondents indicated that veterans' most common complaints involved parking, crime in the facility's local area, and unanswered telephone calls. However, respondents to the VSO and patient advocate questionnaires expressed beliefs that facility leaders had been responsive and provided direct feedback to veterans about their concerns. The Director stated the Chief of Police had attended a town hall with VSO representatives to provide information on actions taken to reduce the impact of crime and improve safety and security at the facility. The Director reported responding to veterans' concerns about lack of telephone responsiveness by hiring a telephone coordinator to work closely with the Office of Information Technology to ensure facility needs are known. The Director stated leaders had set clear expectations on how

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

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

staff manage incoming calls, and the new telephone coordinator was dedicated to ensuring staff met them. The Director reported believing staff had made progress in reducing its telephone abandonment rate (the percentage of phone calls where the caller hangs up before staff answers) and will continue to improve.

Additionally, the Director described hiring a new veterans experience officer to improve the patient advocate program and better address veterans' concerns. After learning that staff had not been responding to congressional letters promptly, the Director said a newly hired congressional liaison had improved the timeliness of responses.

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.[30] 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: "Lt. Col. Luke Weathers, Jr. VA Medical Center," Department of Veterans Affairs, accessed December 23, 2024, https://www.va.gov/memphis-health-care/locations.

Entry Touchpoints

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

[30] VHA Directive 1608(1).

[31] 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.

evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[32]

Transit and Parking

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

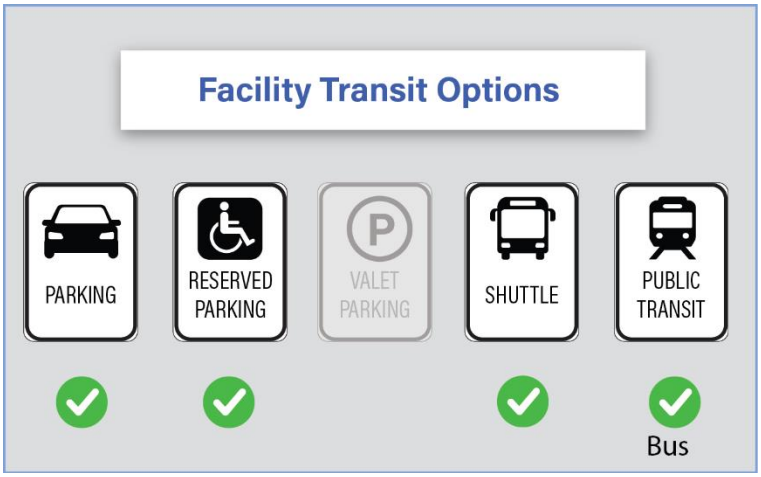


Figure 8. *Transit options for arriving at the facility. Source: OIG analysis of documents and interviews.*

The OIG used two different internet maps to obtain directions and both guided inspectors to the facility. The facility had three public entrances: the bed tower entrance, the Emergency Department, and the spinal cord injury building. The OIG determined there was adequate parking for all entrances. Staff told the OIG they offered a valet service before the COVID-19 pandemic but had not reestablished it.

The OIG observed the Emergency Department had a one-way drive for dropping off veterans at the entrance. Various transportation companies brought veterans into the facility through the spinal cord injury building entrance. In addition, the OIG observed contracted security personnel stationed at parking areas, which the Chief of Police said were present 24 hours a day, seven days a week.

The OIG observed potential safety issues with the crosswalks between the parking garage and the bed tower entrance: faded or worn street markings, missing detectable surfaces (features to alert visually impaired pedestrians to a hazard in the line of travel), and missing crosswalk signs or a warning system (flashing lights or audible warnings) at both sides of the intersection.

Per the VA Site Design Manual, crosswalks are to be marked with "clearly visible painted stripes or by street paving that is consistent with the walkway paving material," detectable warning

[32] 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.

surfaces, and adequate street lighting (see appendix C, figures C.1 and C.2).[33] The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety between the parking garage and bed tower entrance until completion.

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.[34]

The OIG noted exterior signs directing veterans to the facility entrances. The Chief of Police stated contracted security staff were responsible for checking identification at entrances after 6 p.m. The OIG noted the bed tower entrance had an inoperable revolving door and two power-assisted doors separated by a short pathway, with each door activated using buttons on the wall. However, neither power-assisted door had sensors to detect someone in the doorway, allowing the doors to close prematurely and risk injury. In addition, the OIG observed there was no posted notification in the interior lobby about the inoperable revolving door. The OIG also noted two traffic cones with caution tape placed outside of the door on the first day of the site visit, but the tape was on the ground later in the week, leaving veterans unaware the door was inoperable. (see appendix C, figures C.3 and C.4).

Prior to leaving the facility, the OIG requested follow-up regarding the bed tower entrance doors. On June 24, 2024, the Director informed the OIG via email that staff had ordered new sensors to prevent the power-assisted doors from closing when someone was in the doorway, and in the interim, they planned to program the power doors so they would stay open for two minutes after someone pushed the button. The Director also explained that staff planned to reactivate the inoperable revolving door to improve access to this entrance. The OIG recommends facility leaders improve doorway safety at the bed tower entrance by placing sensors on the two power-assisted doors, reactivating the revolving door, and monitoring doorway safety until completion.

The OIG also noted the bed tower and Emergency Department entrances had wheelchairs available just beyond the doors. The entrances were clean and well-lit, with staffed information desks. There was indoor and outdoor seating available at the bed tower entrance and seating in the waiting room adjacent to the Emergency Department entrance.

[33] VA Office of Construction and Facilities Management, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

[34] 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*.

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.[35]

The OIG initially saw that information desks did not have paper maps or a mobile application available to assist veterans in navigating the facility. However, the following day, an information desk staff member had paper maps available. Additionally, the OIG found multiple inaccurate navigational wall signs. For example, some signs that directed people to the Emergency Department routed them to an unstaffed, empty hallway instead. The OIG observed staff had removed these inaccurate signs on the last day of the OIG site visit. The facility's interior designer explained the facility had a funded interior wayfinding project due for installation in October 2024; therefore, the OIG did not make a recommendation.[36]

The OIG observed an emergency exit near the laboratory that had an interior and exterior set of double doors with a small space between them; the exterior double doors were locked and there was a large sign blocking the interior doors, which would create barriers for people attempting to exit the area in the event of an emergency. The OIG visited the area three additional times during the inspection week and observed that staff had moved the sign and unlocked the doors, but the exterior doors were off track and under repair.

Before leaving the facility, the OIG requested a post-visit follow-up with staff regarding this emergency exit to ensure they had completed the repair, and the exit was operating correctly. On June 24, 2024, the Director informed the OIG via email that a device that opened the door was not working, a contractor was on-site doing repairs, and the Director expected the exit to be fully functional that day. The Director verified the door remained unlocked and would open for people to exit in an emergency. The Director further reported moving one of their new weapons detection systems to that door so it could serve as an additional entry point to the facility once repaired. The OIG recommends the Director ensures staff monitor the emergency exit near the laboratory to make sure the door remains unlocked and operational.

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

[36] "An expanded definition of the term wayfinding recognizes that visitors use multiple cues and tools to find their destination – from spatial relationships manifested by the architecture to lighting and interior finishes." Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] The OIG found tactile signs (braille) in buildings and elevators accessed from the bed tower and Emergency Department entrances.[38]

However, the spinal cord injury building lacked tactile signs (braille) and auditory cues. In addition, the OIG found that televisions in public areas did not have closed captioning on to accommodate veterans with hearing impairments.

The OIG recommends the Director assesses the facility's tactile signs (braille) and auditory cues and implements a plan to address deficient areas. Additionally, the OIG requests facility leaders to consider using closed captioning on televisions in public areas.

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents, observations, and interviews.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[39]

Both toxic exposure screening navigators had the responsibility assigned in addition to their primary duties. The OIG inspection team found a navigator's telephone extension on informational posters throughout the facility. However, due to a recent telephone upgrade, it was

[37] 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.

[38] "Tactile requirements primarily apply to signs typically located at doorways because doorways provide a cue for locating signs by touch." Access Board, *Guide to the ABA Accessibility Standards,* "Chapter 7: Signs," accessed June 27, 2024, https://www.access-board.gov/aba/guides/chapter-7-signs/.

[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.

incorrect, and when called, there was no voicemail message. The Director stated staff would update the signs. The OIG also noted the facility had sufficient space for walk-in screenings, and posters that provided veterans with access to a website with PACT Act resources.

The OIG identified that staff had initiated toxic exposure screenings, but those who are authorized to complete them had not done so for over 300 screenings. A navigator stated that missed screens occurred when no provider was available to complete them. The OIG recommends facility leaders evaluate the toxic exposure screening process and implement a plan to ensure staff complete the 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.[40] 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 found that for the first two quarters in FY 2024, staff did not meet the target for closing identified environment of care deficiencies within 14 business days or developing an action plan to address them. The Associate Director attributed it to staff assigning deficiencies to individuals in the incorrect services. The OIG did not make recommendations due to the facility's general overall cleanliness.

General Inspection

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

The OIG inspected several clinical areas and found them clean and well maintained. However, while inspecting the Critical Care Unit and Emergency Department, the OIG found holes in the walls. The nurse managers for the areas explained the holes were created when staff removed wall-mounted sharps containers. Because staff made note of the needed repairs during the inspection, the OIG made no recommendation.

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

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.[41] 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.[42] 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 Chief of Staff acknowledged staff were developing a policy to comply with the July 2023 update to VHA Directive 1088, which allowed facilities 6 to 12 months to create a local policy and service-level workflows (written document) that describe the processes staff use to communicate test results to providers and patients.[43] The Chief of Quality, Safety, and Value (QSV) said staff had created a local policy, standard operating procedures, and service-level workflow processes for critical test results and were reviewing urgent but non-life-threatening test result guidance before the July 2024 deadline.

Action Plan Implementation and Sustainability

Figure 10. *Status of prior OIG recommendations. Source: OIG analysis of a document.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[44]

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

[42] 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.

[43] VHA Directive 1088(1).

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

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 published a hotline healthcare inspection report less than six months prior to the current OIG inspection; the report's five recommendations were open at the time of the site visit.[45] The OIG also identified two open recommendations from a prior VA National Surgery Office site visit on January 26, 2023. The OIG requested information on the status of the action plans for the recommendations, and facility leaders supplied them with revised target dates.

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.[46] 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.[47] 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 QSV explained the facility's continuous learning process started with QSV staff briefing leaders daily on identified deficiencies, actions to address them, and the lessons learned. The Chief of Staff explained that briefing participants then shared the information in smaller, service-level meetings to perpetuate continuous learning.

The Chief of QSV described a monthly patient safety forum for all staff to learn about issues and process improvements in an interactive and engaging manner, including

- holding panel discussions in a "talk show" format for patient safety issues;
- producing easy to understand visual aids of data trends;
- employing storytelling to facilitate continuous learning; and
- creating a space for leaders, such as the Chief of Staff, to have question-and-answer sessions.

The Chief of QSV explained the facility's process for staff tracking open actions (actions that are in the process of implementation or monitored for effectiveness) through committee meeting minutes, assessing trends in patient safety issues across oversight reports, and addressing them through informal QSV department workgroups. To identify themes that are not associated with

[45] VA OIG, *Care Deficiencies and Leaders' Inadequate Reviews of a Patient Who Died at the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis, Tennessee*, Report No. 23-00777-52, January 10, 2024.

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

[47] VHA Directive 1050.01(1).

oversight reports, the Patient Safety Manager said staff most often use the Joint Patient Safety Reporting system.[48]

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[49] 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.[50] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[51] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

After reviewing facility documentation, the OIG noted there were no shortages in primary care provider, registered nurse, or licensed practical nurse staffing. However, according to the documentation, not all primary care teams had a medical support assistant. The Chief, Business Office explained they addressed the shortage of medical support assistants by having them cover more than one team. The Director explained that recruitment for medical support assistants was difficult because the starting pay was low, and it took longer to fill those positions.

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.[52] The OIG

[48] 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*, December 2023.

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

[50] 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).

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

[52] "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).

examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[53]

The OIG reviewed how primary care leaders managed panel sizes. According to a Management and Program Analyst, primary care leaders review panel management reports during weekly meetings. If panel sizes need adjustment to maintain appropriate workload levels, the leaders instruct the analyst to move patients to another panel. The analyst added that once patients are assigned to a panel, they typically stay unless the provider leaves or patients request a change. At the time of the OIG inspection, panels averaged 98 percent of the expected size.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[54] 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 OIG interviewed primary care leaders and staff and found staff had concerns about electronic health record system view alerts affecting their clinical work efficiency and contributing to stress. Leaders supported staff's concerns, and the Associate Chief of Staff for Ambulatory Care indicated providers had challenges managing the high volume of alerts. The Chief of Health Informatics described working with leaders to identify root causes for unaddressed alerts, which included providers not assigning a surrogate when out of the office and staff turnover.

To mitigate the issues, the Chief of Health Informatics reported providing a weekly contingency report that monitors the number of unaddressed alerts to service leaders for follow up. The Associate Chief of Staff for Ambulatory Care reported using the report to identify providers with large numbers of view alerts and teaching them how to better manage them. The associate chief added that facility leaders also reduced the number of mandatory view alerts and educated staff on how to manage the notifications. The OIG recognizes the reported improvements with reducing unaddressed alerts and therefore made no recommendation.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that data showed veteran enrollment had decreased by over 5 percent from FY 2021 compared to August 2023.

[53] VHA Directive 1406(1).

[54] VHA Handbook 1101.10(2).

After interviewing facility leaders, the OIG determined the PACT Act's implementation had not increased veteran enrollment or affected primary care delivery.

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.[55]

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).[56] 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."[57]

The program did not meet the HCHV5 performance target for FYs 2021 through 2023, and the Homeless Program Manager attributed it to insufficient staffing in FYs 2021 and 2022. However, the manager told the OIG the program received and filled two additional positions in FY 2023, which helped staff increase outreach to unsheltered veterans.

HCHV staff stated other barriers to meeting the target included the pandemic, which resulted in more staff interacting with veterans by phone instead of in person. In addition, staff said the facility's homeless program offices relocated in 2023, which some veterans may not have known about and could have affected their engagement with the program. Lastly, staff said increased

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

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

[57] 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.

drug activity in the Memphis area likely deterred veterans from traveling to the facility for shelter services, especially those recovering from addiction. For veterans who wish to remain in their community instead of traveling to the Memphis area for services, staff work with community partners to meet their local shelter and resource needs.

Program staff explained they provide education and outreach to veterans, facility staff, and community partners in the facility's service area.[58] Because of the proximity to Mississippi, Arkansas, and Tennessee, they divide the service area geographically and detailed how outreach varies by location. For example, staff said their primary method is street outreach in Memphis, mainly in the downtown area, which has a dense population of people experiencing homelessness.

In rural areas, staff mainly engage with community partners, such as shelters, hospitals, inpatient mental health hospitals, outpatient alcohol and drug facilities, and churches, for veteran referrals. One staff member highlighted visiting inpatient hospitals in Memphis to meet with veterans who are homeless at the time of their discharge.

Program staff reported interacting with veterans at various stages in their journey from homelessness to permanent housing. In one case, a veteran with a history of drug use had moved from one temporary housing arrangement to the next for about 10 years. Staff said the veteran was skeptical of being approved for the transitional housing program, which bridges the gap from homelessness into permanent housing, but completed the assessment and was approved the next day. The staff said the veteran is now motivated to make positive life changes and currently living in a shelter awaiting a Housing and Urban Development–Veterans Affairs Supportive Housing voucher for permanent housing.

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).[59] The VISN Homeless Coordinator said the HCHV1 and HCHV2 measures were not applicable to the facility because they did not have contract residential beds to place the veterans.[60] However, the coordinator

[58] The facility provides services "in western Tennessee, northern Mississippi, and northwestern Arkansas." "VA Memphis Health Care, About Us," Department of Veterans Affairs, accessed January 16, 2025. https://www.va.gov/memphis-health-care/about-us/.

[59] 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*.

[60] "HCHV CRS [Contract Residential Services] programs target and prioritize Veterans transitioning from literal street homelessness…and require safe and stable living." VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022.

explained the facility had other homeless programs that provided transitional housing for veterans.

Program staff said they hold weekly programs at the Community Referral and Resource Center, which is a community site where the facility's homeless program office is located. During the programs, veterans can discuss benefits eligibility with a VA representative, seek assistance from program staff with housing vouchers, or speak with employment or vocational specialists.[61] To serve rural areas, staff told the OIG they host resource events for veterans at the facility's community-based outpatient clinics.

Staff talked about working with community partners, such as homeless agencies, to support some underserved veterans. Staff also discussed a new community partnership with the Shelby County Library in Tennessee that will provide access to a large database of community resources for homeless veterans. In addition, staff coordinated with a local church for the annual CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) participant survey, where stakeholders and community homeless organizations meet to discuss their needs.[62]

Figure 11. *Facility's current community partnerships.*
Source: OIG analysis of document.

[61] "CRRCs [Community Referral and Resource Centers] provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multiagency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits." "VA Homeless Programs," Department of Veterans Affairs, accessed June 11, 2024, https://www.va.gov/HOMELESS/crrc.

[62] Project CHALENG is an event where veterans and the community meet to identify and plan for the needs of homeless veterans. Department of Veterans Affairs, "Veterans Health Administration (VHA) Homeless Programs Office (HPO) Fiscal Year (FY) 2022 Fact Sheet," May 2023.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[63] 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.[64]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[65] The program exceeded the performance measure target in FY 2023. The Section Chief for Mental Health, Social Work, and Recovery Programs told the OIG that program staff conduct outreach and education at the facility and law enforcement agencies, in addition to participating in veteran resource fairs, where staff provide program information to veterans. The section chief said program staff work closely with local jails, prisons, courts, attorneys, and community homeless coalitions to identify and enroll veterans in the program.

The section chief explained that while staff did a good job at outreach, the program was insufficiently staffed to cover all rural areas. However, leaders support the program by having other facility homeless program staff assist with outreach.

The Health Care for Reentry Veterans Services Program Coordinator told the OIG that staff are also assigned prison outreach for two other VISN 9 facilities; their goal is to help veterans into housing as quickly as possible after release.[66] The coordinator added that staff receive referrals from prison staff, family members, and veterans in prison; and conduct prison outreach in person or via video technology.

Meeting Veteran Needs

The Section Chief for Mental Health Recovery Programs told the OIG that some counties had veteran treatment courts, which those eligible completed mental health or substance abuse treatment programs as an alternative to being incarcerated, noting that rural areas would benefit

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

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

[65] 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*.

[66] The Health Care for Reentry Veterans Services (HCRV) "program provides pre-release outreach, assessment, linkage, and brief post-release case management services for incarcerated Veterans released from state and Federal prisons." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

from more of these courts.[67] The section chief stated the facility held a monthly legal clinic with a community partner, and recently VHA had made grants available for medical-legal partnerships that would provide free legal services to 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."[68] 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.[69]

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).[70] The OIG found the program did not meet the target for FYs 2021 through 2023. The Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager said the biggest barrier to meeting the target was not having enough staff to enroll veterans in the program.

The manager explained that, during FY 2023, staffing stabilized when the facility offered retention bonuses and increased salaries for social workers. At the time of the OIG inspection, the manager stated the program was on track to meet the target for FY 2024.

The Housing and Urban Development-Veterans Affairs Supportive Housing Program Manager explained that staff visited veterans after they secured housing to help with life skills. These visits often turned into talks over coffee, then veterans who lived at the housing units started having weekly coffee socials and sometimes barbeques. The manager stated the events provided veterans who had been isolated with opportunities to become more comfortable socializing, adding that the coffee socials became so popular that veterans started hosting celebrations.

Figure 12. *Best practice for program outreach and veteran engagement.*
Source: OIG interview.

[67] 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.

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

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

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

The manager told the OIG that staff received referrals from veterans, facility staff, and community partners; participated in the annual point-in-time count; and accompanied other homeless program staff to conduct rural outreach.

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).[71] The OIG found the program met the target for FYs 2021 through 2023.

The Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager stated the program has two vocational rehabilitation specialists who work with employers in the community to help veterans secure jobs, and veterans meet with program employment specialists at a monthly walk-in clinic. The manager explained staff screen veterans for housing voucher eligibility and encourage them to attend group classes where staff help them complete public housing authority applications. Once veterans received housing, the manager said staff, peer specialists, and substance use disorder program staff continue helping veterans maintain stable housing and achieve treatment goals.

The manager told the OIG that the VHA National Homeless Programs Office provided a landlord list, and staff conducted community outreach to find landlords with safe, good quality properties. The manager stated staff also conduct housing fairs to connect landlords to veterans and invited local public housing authority staff. The manager identified the lack of safe housing in the Memphis metropolitan area as a barrier to housing veterans and reported believing drugs are more readily accessible in the area, which could jeopardize a veteran's sobriety. The manager also stated that during the pandemic, public housing authority staff began working virtually and had not returned to their offices, which made it difficult for veterans to communicate with them.

The manager shared a story of a veteran who visited the facility's drop-in center (a place where homeless veterans could access services) and over time developed trust with the program staff. The staff helped the veteran apply for Social Security benefits, access a transitional housing program, and then find permanent housing. Once permanently housed, the veteran started school, got a dog, and eventually found their own apartment.

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

Conclusion

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

OIG Recommendations and VA Responses

Finding: Crosswalks between the parking garage and the bed tower entrance had faded or worn street markings, missing detectable surfaces, and missing crosswalk signs or a warning system at both sides of the crosswalk intersection.

Recommendation 1

The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety between the parking garage and bed tower entrance until completion.

__X__ Concur

____ Nonconcur

Target date for completion: March 30, 2025

Director Comments

The nine crosswalks in the parking lot area were painted December 20, 2024, in a manner to improve crosswalk visibility. The crosswalks are scheduled to be re-painted due to fading in some areas, caused by winter weather conditions in the interim since being painted. Engineering Service will complete the repainting of the crosswalk by March 21, 2025, and confirm completion to facility leadership (Medical Center Director) through the Quality and Patient Safety Committee (QPSC) monthly meeting. Monitoring of pedestrian safety is done through continual observation by VA Police and security personnel patrolling the premises, and VA staff and volunteers whose duty areas or travel paths have a line of sight of the area between the parking garage and the bed tower entrance.

Finding: The bed tower entrance had an inoperable revolving door and two power-assisted doors separated by a short pathway and activated by buttons on the wall. Neither door had sensors to detect someone in the doorway, allowing the doors to close prematurely, which created a risk of injury.

Recommendation 2

The OIG recommends facility leaders improve doorway safety at the bed tower entrance by placing sensors on the two power-assisted doors, reactivating the revolving door, and monitoring doorway safety until completion.

__X__ Concur

____ Nonconcur

Target date for completion: April 30, 2025

Director Comments

In June of 2024, presence sensors were installed on the two power-assisted doors, and the hold-open time was adjusted to two minutes. Direct observation of the sensors and hold-open time properly functioning was done by Engineering Service at the time of the installation, and they reconfirmed proper functioning on February 13, 2025. Engineering Service is working with a local vendor to secure parts for the repair of the revolving door. Due to the complexity of the door and challenges locating parts, the repair of the revolving door remains in progress; however, it is anticipated that the revolving door will be repaired and reactivated to function by April 30, 2025. The status on the repair of the revolving door will be reported to facility leadership (Medical Center Director) through the Quality and Patient Safety Committee (QPSC) monthly meeting.

Finding: The emergency exit near the laboratory was locked and a large sign was blocking doors, creating barriers to exiting the area in case of an emergency.

Recommendation 3

The OIG recommends the Director ensures staff monitor the emergency exit near the laboratory to make sure the door remains unlocked and operational.

__X__ Concur

____ Nonconcur

Target date for completion: March 31, 2025

Director Comments

As stated in the report, the facility unlocked the emergency exit door while OIG was still present for the site visit. To monitor the safety and functioning of the emergency exit door, the Assistant Medical Center Director worked with the facility Chief of VA Police to ensure that VA Police Officers conducted checks on the door as part of their routine morning rounds. The status of emergency exit doors will be reported during the Medical Center Director's morning huddle, and if the emergency door is found to be locked it will be unlocked immediately by the rounding officer. The VA Police Chief will report any issues that impede the door from functioning as an emergency exit to the Assistant Medical Center Director, and that information will be reported at the monthly Quality and Patient Safety Committee (QPSC) meetings. Engineering Service will be notified of any emergency door repair needs that are found, which will also be included in reporting to QPSC until the issue is resolved.

Finding: The spinal cord injury building lacked tactile signs (braille) and auditory cues to assist people who are blind or have low vision.

Recommendation 4

The OIG recommends the Director assesses the facility's tactile signs (braille) and auditory cues and implements a plan to address the deficient areas.

__X__ Concur

____ Nonconcur

Target date for completion: March 31, 2025

Director Comments

The facility Interior Designer assessed the Spinal Cord Injury Building on February 18, 2025, for appropriate tactile signage needs. The Interior Designer will ensure procurement and installation of tactile signage by March 7, 2025. The status of the tactile signage will be reported to facility leadership (Medical Center Director) through the Quality and Patient Safety Committee (QPSC) monthly meeting until completion is confirmed.

Finding: Facility staff had not completed more than 300 toxic exposure screenings.

Recommendation 5:

The OIG recommends facility leaders evaluate the toxic exposure screening process and implement a plan to ensure staff complete the screenings.

__X__ Concur

____ Nonconcur

Target date for completion: June 30, 2025

Director Comments

Facility Primary Care Leadership reviewed toxic exposure screening (TES) processes to identify areas for improvement. As of February 18, 2025, there were 225 remaining toxic exposure screenings (TES) needing follow-up completion. Primary Care Provider (PCP) training was reviewed to address any knowledge deficits, and a refresher training is scheduled to be completed February 20, 2025, to reinforce staff's knowledge of roles and responsibilities for the screening process. The Licensed Independent Practitioner (LIP) for each Patient-Aligned Care Team (PACT) will be responsible for ensuring their TES patient screening follow-ups are completed and the PACT Act Physician will be responsible for completing TES of any patients without an assigned PACT. The Associate Chief of Staff, Ambulatory Care will monitor the TES

follow up list every two weeks. The status of progress towards completion of screenings will be monitored using the PACT Act VSSC Toxic Exposure Screening Reporting in the Power-BI dashboard. Primary Care will report monthly to the facility Medical Executive Board (MEB) on the status of TES completions, which will be reported to facility leadership through Executive Leadership Council. Target goal is less than 25 unresolved TES that need follow up completion.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs. 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 20 through 23, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

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

[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.

[4] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

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.

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.

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

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

Appendix C: Facility Photos

Figure C.1. *Photo of crosswalk from parking garage to sidewalk leading to the bed tower entrance.*
Source: Photo taken by OIG inspector.

Figure C.2. *Photo of crosswalk from sidewalk to the bed tower entrance.*
Source: Photo taken by OIG inspector.

Figure C.3. *Photo of power-assisted doors at the bed tower entrance.*
Source: Photo taken by OIG inspector.

Figure C.4. *Photos of barriers used to inform visitors of an inoperable revolving door at the bed tower entrance taken two days apart during the OIG's on-site visit.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 24, 2025

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee

To: Director, Office of Healthcare Inspections (54HF03)

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee. I concur with the findings, recommendations, and action plans submitted by the Memphis VA Medical Center Director.
2. We thank the OIG for the opportunity to review and respond to the Report: Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee.

(Original signed by:)

Gregory Goins, FACHE
Network Director, VISN 9

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: February 19, 2025

From: Director, VA Memphis Healthcare System (614)

Subj: Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee

To: Director, VA MidSouth Healthcare Network (10N9)

1. Attached please find the Memphis VA Medical Center's response to the OIG Draft Report, Healthcare Facility Inspection of the VA Memphis Healthcare System in Tennessee.

2. If there are any further questions regarding this response, please contact Quality and Patient Safety, Lt. Col Luke Weathers, Jr. VA Medical Center.

(Original signed by:)

Joseph Vaughn, MBA, FACHE

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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.