US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Oklahoma City Healthcare System in Oklahoma

Healthcare Facility Inspection	24-00596-129	May 28, 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 Oklahoma City Healthcare System (facility) from August 27 through 29, 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 disrupts healthcare operations), leadership communication, and both employees' and veterans' experiences. Facility leaders identified system shocks as the destruction of a clinic from a natural disaster, numerous floods, and major construction projects to address outdated infrastructure and the increasing veteran population. Despite these challenges, leaders described a culture of engagement and teamwork. The OIG's review found leaders had taken actions to improve communication and encourage staff to report concerns. Most OIG questionnaire respondents indicated they were comfortable suggesting actions to improve the work environment and agreed the facility's culture was moving in the right direction. Additionally, leaders stated they communicated with local veterans service organizations to address veterans' concerns.[2]

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

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

Environment of Care

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

The OIG successfully reached the facility by following directions from a navigational link on the facility website; signs from parking areas also directed veterans to two main entrances. Greeters assisted veterans with directions; however, the OIG team observed delays at the elevators that caused veterans to use the stairwells. The OIG witnessed veterans, including one with portable oxygen, struggle to climb the stairs and request assistance from bystanders. The OIG observed the facility was generally clean; however, some medical equipment lacked preventive maintenance stickers. Additionally, one piece of equipment had a sticker that indicated it required preventive maintenance, but another piece of the same type of equipment had a sticker indicating it did not. Improperly maintained equipment may cause harm or injury to patients and staff. The OIG made two recommendations.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The facility had processes to identify improvement opportunities as part of continuous learning, and no recommendations from previous OIG reports remained open.

Leaders had established processes to communicate urgent, noncritical test results to ordering providers, but had documented these processes as standard operating procedures. VHA requires each facility to develop a policy for the communication of test results.[3] The OIG requests facility leaders to consider updating the standard operating procedure to a policy. Additionally, the OIG was unable to verify the Acting Chief of Staff or the Associate Director, Patient Care Services attended meetings to monitor communication of test results data. The OIG would expect these leaders to be aware of quality data and ensure staff take corrective actions.[4] The OIG made one recommendation.

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

[4] The VA medical facility's chief of staff and associate director for patient care services are responsible for "reviewing data related to the compliance with this directive (e.g., EPRP CTR [External Peer Review Program communication of test result] measures, VA medical facility test results communication performance monitoring data) and ensuring corrective action is taken when non-compliance is identified." VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[5] Primary care leaders explained they had seen an increase in enrollees since implementation of the PACT Act; however, leaders were able to ensure timely access to care by adding a clinic for newly enrolled veterans to be seen the same day, if needed, rather than wait for an appointment with their assigned provider.

The OIG noted the facility had multiple primary care provider and licensed practical nurse vacancies, which led to some team members working through lunch or beyond their scheduled hours. However, the OIG identified only a few primary care teams that were above 100 percent patient capacity. Primary care leaders said this was due to 437 new veterans enrolled in the month before the site visit. Both facility and primary care leaders said they were recruiting additional licensed practical nurses, and they had already hired multiple providers to assist the teams.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the facility had active homeless programs, with a strong emphasis on outreach services and connections with multiple community partners to assist veterans. Program staff discussed several barriers to housing veterans: limited housing availability and veterans' lack of income. The OIG found that staff coordinated services with facility staff and community partners and established relationships with landlords to address veterans' needs.

What the OIG Recommended

The OIG made three recommendations for improvement.

1. Facility leaders ensure all veterans and visitors, including those who require mobility assistance, have safe and accessible pathways to clinical areas during elevator repairs.
2. Facility leaders ensure staff complete and document preventive maintenance for medical equipment.

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

3. The Chief of Staff and the Associate Director, Patient Care Services ensure staff record their attendance at meetings where staff monitor the communication of test result data.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes D and E, and the responses within the body of the report for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Oklahoma City Healthcare System
Oklahoma City, Oklahoma
Level 1b-High Complexity
Oklahoma County
Hospital Referral Region: Oklahoma City

Description of Community

POPULATION

Female **1,297,997**	Male **1,283,175**
Veteran Female **22,345**	Veteran Male **170,467**

Homeless - State **3,754**
Homeless Veteran -State **273**

MEDIAN INCOME

$51,270

EDUCATION

87% Completed High School
51% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **209**

SUBSTANCE USE

26.9% Driving Deaths Involving Alcohol
14.4% Excessive Drinking
527 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	941,245
Carpool	110,829
Work at Home	60,624
Walk to Work	20,317
Other Means	15,249
Public Transportation	4,525

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**40 Minutes, 37 Miles**
Specialty Care	**93 Minutes, 92 Miles**
Tertiary Care	**95 Minutes, 104 Miles**

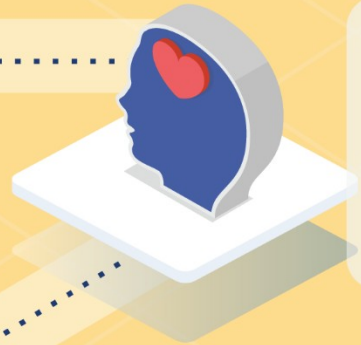
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **25,051**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	39%
<65 without Health Insurance	21%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

18,458

444 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.72 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
28	46

Health of the Facility

UNIQUE PATIENTS

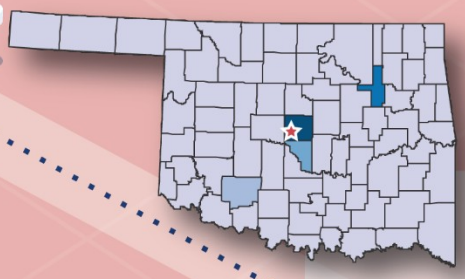
Unique Patients VA and Non-VA Care	78K
Unique Patients VA Care	74K
Unique Patients Non-VA Care	31K

COMMUNITY CARE COSTS

Unique Patient $23,681	Outpatient Visit $302
Line Item $1,043	Bed Day of Care $280

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.87%
Facility Total Loss Rate	11.67%
Facility Retire Rate	1.96%
Facility Quit Rate	8.49%
Facility Termination Rate	1.01%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.04% 4.04% 8.03% 12.02% 16.01% 20.01%

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

Contents

Background and Vision

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

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

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

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

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

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]

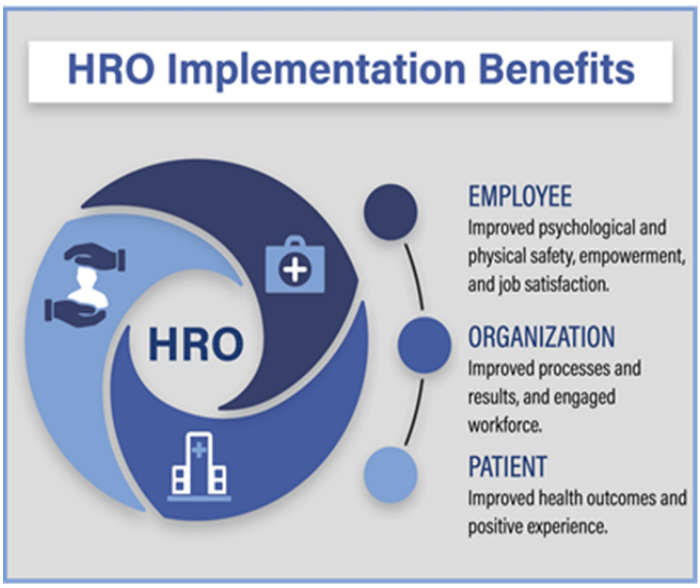


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 leaders who prioritize HRO principles increase employee engagement and improve patient

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

[12] "VA PACT Act Performance Dashboard," VA. On 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 VA Oklahoma City Healthcare System (facility) began serving patients on July 15, 1946. At the time of the OIG's inspection, the executive leaders consisted of the Director; Associate Director; Acting Chief of Staff; Associate Director, Patient Care Services; Assistant Director; and Assistant Director of Operations. The newest members of the team were the Assistant Director of Operations and Acting Chief of Staff, both assigned in 2023; the Director had been in place since May 2016. The facility had 193 operating beds (146 hospital, 31 community living center, and 16 compensated work therapy transitional residence beds), and a fiscal year (FY) 2023 medical care budget of approximately $1 billion.[13]

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

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed March 20, 2025, https://www.va.gov/VA_CLC. Compensated work therapy assists veterans with resources and support to return to the workforce. "Compensated Work Therapy," Department of Veterans Affairs, accessed March 31, 2025, https://www.va.gov/Health/CWT.

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

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

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

System Shocks

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

Figure 4. *Associate Director of Resources comments on facility systems shocks.*
Source: OIG interview.

In interviews, facility leaders told the OIG about several shocks to the organization, including the destruction of a clinic due to a tornado, numerous floods, and major construction projects to address outdated infrastructure and growing veteran population. The Director said a tornado destroyed a clinic six months after it opened in 2022, and another clinic closed in 2023 due to a flood caused by a broken pipe. Leaders added that other flooding incidents were related to aging infrastructure and pipe damage from extreme temperatures. The Director said although they replaced water pipes in the main building, floods reoccurred due to the freezing temperatures. Leaders added they had to redirect thousands of veterans to alternative locations while addressing the floods in the clinic and main facility.

Leaders highlighted the increasing number of veterans seeking care at the facility and the limited healthcare resources, primarily in rural areas, as issues affecting the organization. The Director attributed the higher demand for care to closures of local healthcare facilities after the COVID-19 pandemic. To address the need, the Director discussed expanding services to include more staff, specialty care, and dental services in community-based outpatient clinics. Additionally, leaders said they referred veterans to other nearby VA medical facilities for some specialized care and offered new enrollees same-day appointments for immediate care needs.[19]

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

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

[19] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed December 23, 2024, https://www.va.gov/CommunityCare.

To improve the infrastructure and serve more veterans in rural areas, the Director outlined major construction projects in various stages of completion:

- New substance abuse treatment facility
- Expanded community living center and two community-based outpatient clinics
- New women's health clinic
- Improved plumbing and heating
- Modernized elevators
- New parking garage

The OIG's facility-wide questionnaire showed many respondents had not observed system shocks within the past three years.[20] Leaders reported having a well-organized emergency response system for disasters and stressed the importance of communication with staff and veterans. Despite the adverse events and challenges, leaders stated veterans remained able to access care and staff maintained patient care services.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] 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.[22] 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."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency,

Figure 5. *Leader communication with staff.*
Source: OIG interview and responses to the facility-wide questionnaire.

[20] The facility had 2,897 employees; 328 of them responded to the OIG questionnaire.

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

[22] 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*.

[23] 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.

communicated with staff, and shared information.[24]

The VA survey scores indicated staff perceptions of leaders' communication had improved from FY 2021 to FY 2023. In interviews, leaders emphasized the importance of eliciting feedback on staff's preferences for communication. Leaders also highlighted they exchange information in the Director's daily meeting and disseminate it to managers and staff through Microsoft Teams channels for faster communication and prompt problem resolution.[25] Leaders said they communicate with staff through town halls, emails and newsletters, and regular visits to staff in their work areas.

Leaders also shared that communication with staff in the community-based outpatient clinics had been challenging in the past, but it improved after they added the assistant director of operations position, hired more nurse managers, and involved clinic leaders in the facility leaders' morning meeting.

[24] 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.

[25] Microsoft Teams is a messaging application used by organizations to meet, collaborate, and share files. "What is Microsoft Teams," Microsoft, accessed March 25, 2025, https://support.microsoft.com/what-is-microsoft-teams.

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] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

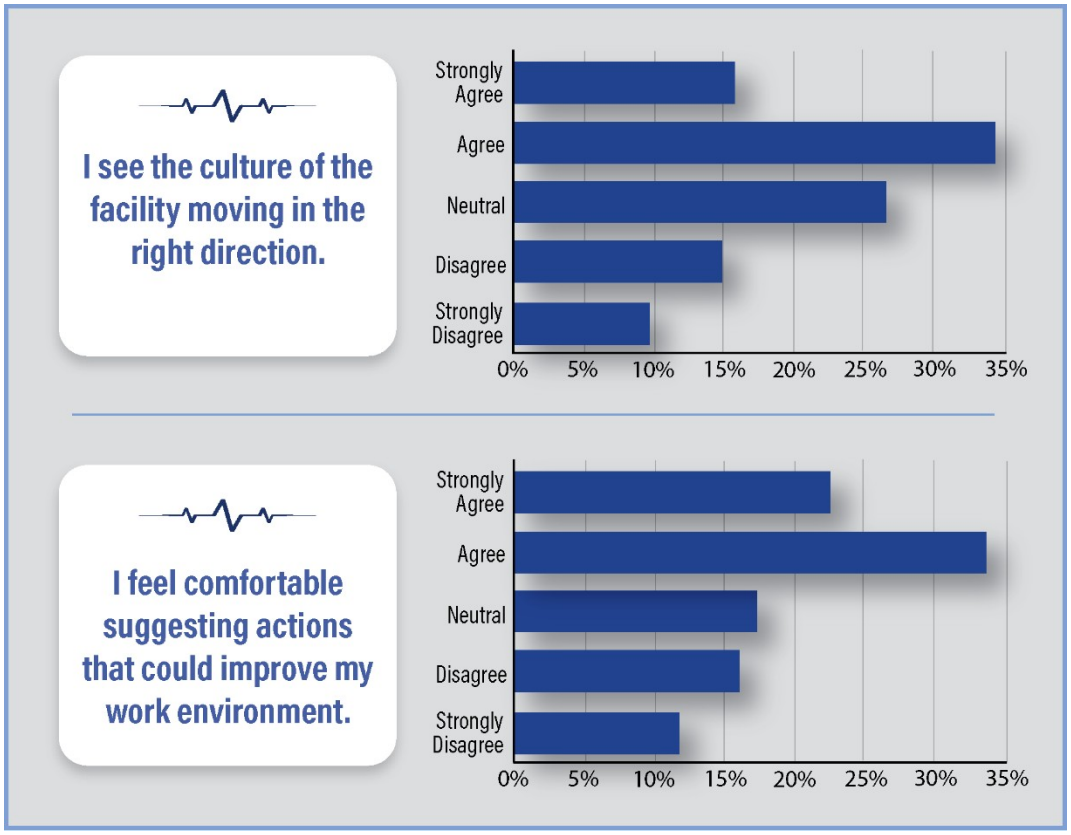


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

[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.

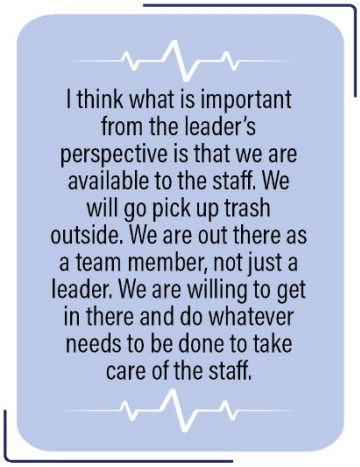


Figure 7. *Assistant Director for Facilities' comments on the employee experience. Source: OIG interview.*

The OIG also reviewed VA survey scores for employee satisfaction and found the best places to work score decreased from FYs 2021 to 2022 but increased from FYs 2022 to 2023.[28] Leaders attributed the initial decline to challenges providing care during the pandemic, and the Director attributed the subsequent improvement to addressing employees' concerns, especially for workload.

Leaders reported trying to increase staffing to reduce the workload, and the Director shared specific initiatives that included using workers' compensation (employees who were unable to perform their primary jobs due to injury but able to fill other roles) and contract employees to increase the workforce. The Director also stated that environmental management service contracted employees worked additional hours, which reduced facility employees' workload. Leaders added that they offered recruitment incentives and flexible schedules and consulted with Veterans Integrated Service Network leaders to address hard-to-fill positions.

During an interview, the OIG learned the facility had a wellness program to help employees manage stress and burnout with activities such as yoga, wellness education, exercise challenges, and walks with leaders. Leaders also worked alongside employees to demonstrate teamwork and hear feedback and recognized them for going above and beyond by sending written praise.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. VA survey scores for psychological safety had increased from FY 2021 to FY 2023, and the OIG questionnaire showed most respondents felt comfortable reporting patient and employee concerns and suggesting actions to improve the work environment.

[28] Best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[29] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[30] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Patient advocates and VSOs agreed that facility leaders were responsive to veterans' concerns. The most common concerns VSOs noted involved parking. During the site visit, the Director discussed a construction project to build a new parking garage and emphasized that staff maintain ongoing communication with VSOs to address veterans' concerns.

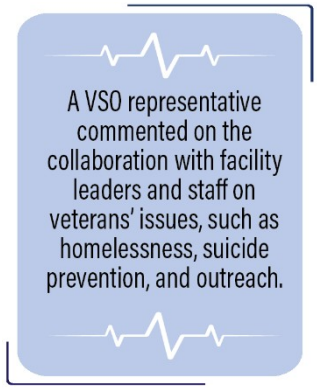


Figure 8. *VSO's comment. Source: VSO questionnaire.*

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.[31] 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 9. *Facility photo. Source: "VA Oklahoma City Health Care Locations," Department of Veterans Affairs, accessed September 19, 2024, https://www.va.gov/oklahoma-city-health-care/locations.*

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

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

[31] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[32] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[33]

Transit and Parking

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

The OIG successfully used a navigation link from the facility's website to reach the site. Upon arrival, the OIG found signage that directed veterans to parking and building entrances. The OIG observed available parking and shuttle bus areas.

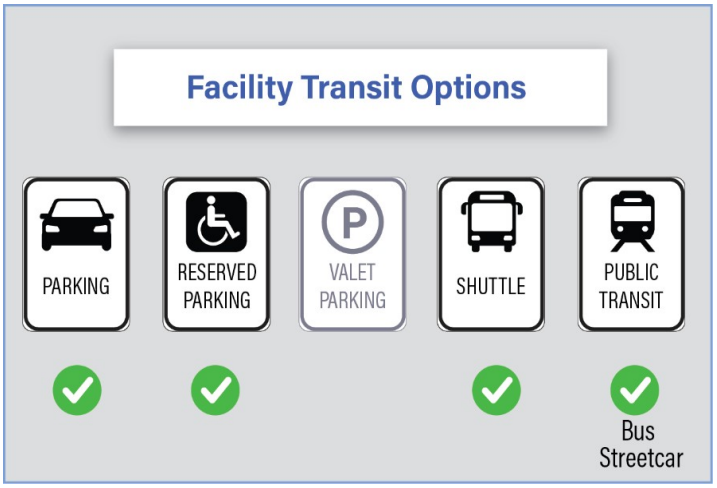


Figure 10. *Transit options for arriving at the facility. Source: OIG analysis of documents and observations.*

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 two main entrances to the facility. During an interview, the Comprehensive Environment of Care Committee Chair said a new parking garage had inadvertently created the additional entrance. Both entrances were accessible through

[32] 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.

[33] 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.

[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*.

automatic doors, with wheelchairs available and greeters stationed inside at information desks. The OIG found the entrances clean and welcoming, with windows, natural lighting, and sufficient seating.

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 observed greeters providing directions for veterans requiring assistance and noted a large, color-coded wall map. However, multiple elevators were out of service during the inspection, causing veterans to wait or use stairwells. The OIG witnessed veterans, including one with portable oxygen, struggling to climb the stairs and requesting assistance from bystanders. The OIG recommends facility leaders ensure all veterans and visitors, including those who require mobility assistance, have safe and accessible pathways to clinical areas during elevator repairs.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] Through questionnaire responses and direct observation, the OIG learned that sensory impaired veterans could request an escort and assistive listening devices to help them find their way around. Nursing Managers in the community living center and critical care units said they consult with the Audiology Service to obtain assistive devices when veterans struggle to communicate during their care. The OIG team observed two veterans using assistive devices provided by the facility. In addition to the large

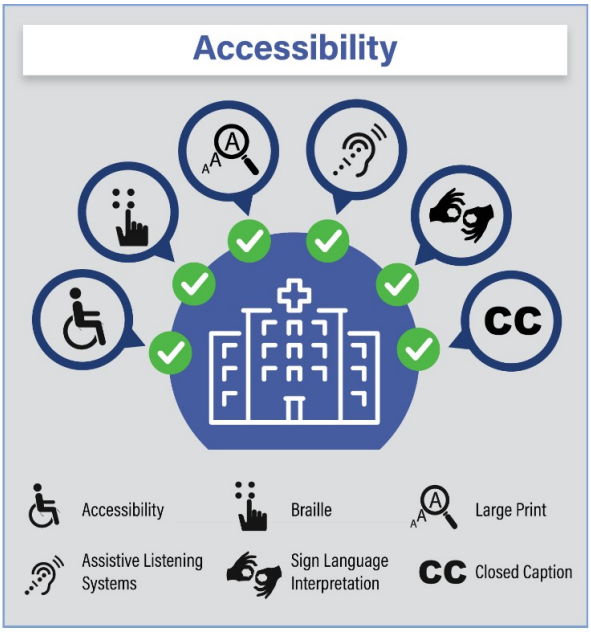


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations, email, and questionnaire responses.

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

[36] 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.

wall map, the OIG noted braille characters on elevator buttons, audible elevator tones, and closed captioning on monitors near the information desks.

Toxic Exposure Screening Navigators

VA recommends that each facility 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.[37] The OIG learned through questionnaire responses the facility had one navigator and two back-up navigators; staff reported wait times for screenings were under 30 days.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[38] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed facility documentation outlining plans of action in response to Comprehensive Environment of Care inspections and identified repeat deficiencies related to stained ceiling tiles and ceiling leaks throughout the facility. The Comprehensive Environment of Care Committee Chair and the Director provided documentation identifying continuous improvement efforts, including construction plans, to address stained ceiling tiles caused by water intrusion from aging infrastructure. The Assistant Director reported hiring an employee to identify the stained ceiling tiles and replace them. Because the leaders were aware of and addressing this issue, the OIG did not make a recommendation.

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.

[37] 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.

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

The OIG physically inspected five patient care areas and found them to be clean and without privacy concerns. However, the OIG also found medical equipment that lacked preventive maintenance stickers, as well as similar pieces of equipment with inconsistent preventive maintenance documentation. For example, a sticker on one piece of equipment indicated it required preventive maintenance, while another sticker on the same type of equipment did not (see photo in appendix C).[39] When staff do not maintain equipment, there may be a risk of harm or injury to patients and staff. The OIG recommends facility leaders ensure staff complete and document preventive maintenance for medical equipment.

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.[40] 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.[41] 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 facility had processes for staff to communicate test results to ordering providers, identify designees when ordering providers were unavailable or had left the facility, and communicate results outside regular clinic hours when needed. VHA requires that each facility has a policy for the communication of test results.[42] The OIG found that leaders did not have a policy and instead developed a standard operating procedure. The Director, Office of Quality, Safety, and Value reported developing the standard operating procedure due to misinterpreting the requirement.

[39] The medical equipment with preventive maintenance documentation problems included beds, vital sign machines, a patient lifting machine, and a medication refrigerator.

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

[41] 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.

[42] VHA Directive 1088(1).

The OIG requests that facility leaders update it to a policy but did not make a recommendation because the standard operating procedure met the intent of the directive.[43]

Additionally, facility staff informed the OIG that attendees at the External Peer Review Program meetings monitor communication of test result data and actions staff take to address deficiencies.[44] The Acting Chief of Staff and Associate Director, Patient Care Services said they attend these meetings; however, the OIG was unable to verify their attendance. The OIG would expect these leaders to be aware of quality data for oversight of decisions that affect patient care. The OIG recommends the Chief of Staff and the Associate Director, Patient Care Services ensure staff record their attendance at meetings where staff monitor the communication of test result data.[45]

Based on a review of patient safety events and comments in the facility-wide questionnaire, the OIG was also concerned that personnel issues in the laboratory were affecting safe patient care. The Director was aware of the concerns and explained that leaders had taken multiple personnel actions to address the issues. The Director added that multiple external agencies had conducted audits and inspections to determine whether patient care had been affected.[46] After the inspection, an employee from the laboratory emailed the OIG's Healthcare Facility Inspection team a list of patients that, in their opinion, had experienced delays in care. The Healthcare Facility Inspection team notified the OIG's hotline team of the concerns and therefore did not make a recommendation in this report.

Action Plan Implementation and Sustainability

Figure 12. *Status of prior OIG recommendations.*
Source: VA OIG.

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

[43] VHA Directive 1088(1).

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

[45] The OIG reviewed evidence sufficient to demonstrate staff had completed improvement actions and therefore closed the recommendation prior to the report's publication.

[46] The VA Pathology and Laboratory Medicine, National Enforcement Office conducted a routine audit in April 2023 and did not note any critical or repeat findings. The Joint Commission inspected the facility's laboratory in October 2022, June 2023, September 2023, December 2023, and January 2024. As a result of these inspections, staff developed an action plan that addressed unlabeled or mislabeled specimens and monitoring of mislabeled specimens.

HRO.[47] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether determine action plans were implemented, effective, and sustained. The OIG found no open recommendations from a previous healthcare inspection report.[48]

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.[49] 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.[50] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In an interview, the Director, Office of Quality, Safety, and Value reported reviewing quality data, including peer reviews and patient safety reports, to help identify opportunities for improvement.[51] Other facility leaders told the OIG they shared lessons learned in employee town hall, patient safety, and service-specific meetings.

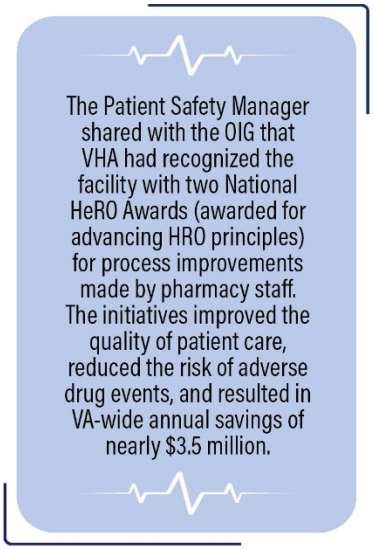


Figure 13. *Staff-identified opportunities for improvement. Source: OIG analysis of documents and interview.*

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

[48] VA OIG, *Comprehensive Healthcare Inspection of the Oklahoma City VA Health Care System in Oklahoma*, Report No. 21-00253-239, September 2, 2021.

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

[50] VHA Directive 1050.01(1).

[51] A peer review "is a critical review of care performed by a peer" to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[52] 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.[53] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[54] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

A staff member provided the OIG a list of primary care vacancies prior to the site visit, which included multiple providers. In an interview, the Business Manager said the rural nature of the area led to challenges filling the positions. The manager also stated the facility has a physician recruiter, who uses various approaches to attract candidates, including posting in medical journals. The Acting Chief of Staff added they use incentives, such as educational debt reimbursement, to entice providers to the positions.

The primary care staff described a shortage of licensed practical nurses, which led to registered nurses working through lunches and staying beyond their tour of duty to complete the work. When the OIG discussed this concern with primary care leaders, they said they were aware of the shortage. The Chief of Nursing for Primary Care reported actively recruiting additional licensed practical nurses. Because leaders were aware of and addressing staffing issues, the OIG did not make a recommendation.

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.[55] The OIG

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

[53] 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).

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

[55] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On 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.[56]

In a review of primary care data, the OIG noted that only a few teams were above 100 percent capacity, which leaders attributed to 437 new veteran enrollees in the month prior to the site visit. The Acting Chief of Staff said leaders had taken several actions, including hiring multiple providers and using float providers to assist teams.[57]

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] 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.

During an interview, primary care staff told the OIG it was difficult to accommodate walk-in veterans. To improve efficiency, primary care nurses said they piloted a triage process in which nurses see walk-in veterans and attempt to resolve their issues. If the nurse felt the veteran needed more than a brief visit, they could offer a same-day appointment with a provider or an express clinic visit.[59] Primary care staff believed this process had improved efficiency.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found veteran enrollment had increased following the act's implementation, and primary care leaders described adding resources to ensure access to care, such as a clinic where new enrollees could be seen the same day instead of waiting for an appointment with their assigned primary care provider.

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.

[56] VHA Directive 1406(1).

[57] Float providers fill a temporary (for extended leave or vacant positions) gap in coverage.

[58] VHA Handbook 1101.10(2).

[59] With express clinic visits, veterans with acute symptoms can receive care in-person, via phone, or through video calls with a provider at a different location.

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.[60]

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).[61] 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."[62]

The program did not meet the HCHV5 target in FY 2021 but exceeded it in FYs 2022 and 2023. In an interview, program staff said the COVID-19 pandemic limited outreach in FY 2021. The staff attributed meeting the targets the other two years to collaboration with community partners to identify unsheltered veterans.

Staff reported the point-in-time count also helped identify unsheltered veterans. Additionally, they received referrals from facility and community providers. Staff explained that outreach was an effective way to build relationships and establish trust with the veterans to engage them in services. They reported no barriers to enrolling veterans in the program.

> The Healthcare for Homeless Veterans social worker informed OIG that the facility had a Safe Parking Program. The program included three designated spaces where homeless veterans could park and stay in their cars overnight, while receiving support services such as laundry, shower, food, and housing assistance.

Figure 14. *Best practice for veteran engagement.*
Source: OIG interview.

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

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

[62] 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.

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).[63]

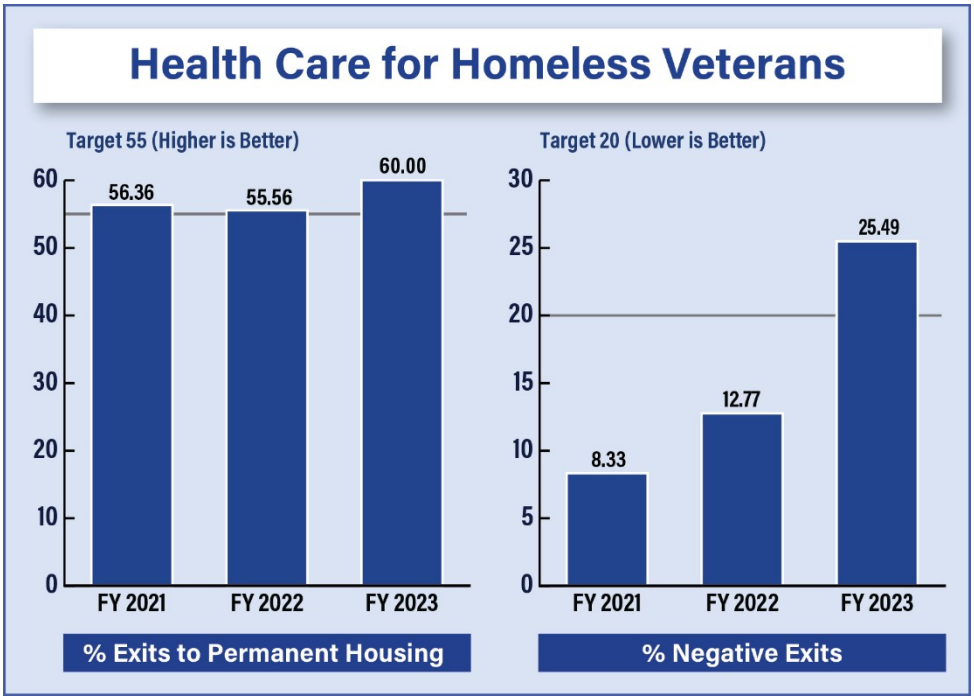


Figure 15. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program exceeded the HCHV1 target for FYs 2021 through 2023. In an interview, program staff reported factors contributing to this success included meeting regularly with veterans to build rapport and discuss ways to meet their goals. Additionally, the program exceeded the HCHV2 target in FYs 2021 and 2022 but did not meet it in FY 2023. Staff stated some facilities only allowed veterans to leave the residence for one hour per day, which caused them to leave the program. Staff also said one incident involved veterans engaging in a physical altercation with each other; two veterans were incarcerated; and others had positive drug screens, all resulting in negative discharges. Program staff discussed strategies to improve in this area, including meeting with veterans weekly to address their residential concerns and help prevent negative discharges.

[63] 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*.

Program staff said some enrolled veterans need medical care; mental health and substance use disorder treatment; as well as transportation, housing, benefit, legal, financial, and vocational assistance. The staff described referring enrolled veterans to VA and community partners to address their needs.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[64] 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.[65]

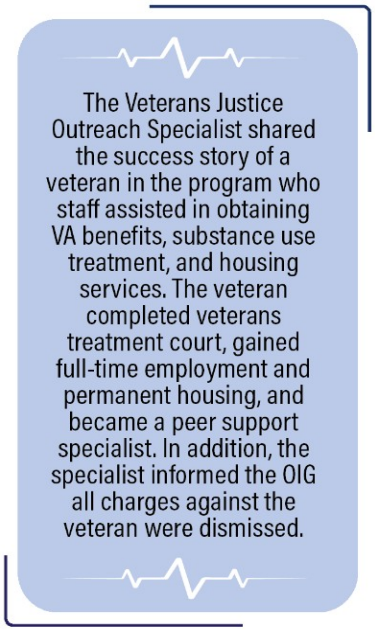


Figure 16. *A Veterans Justice Program success story. Source: OIG interview.*

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[66] The program exceeded the target during FY 2023. The Veterans Justice Outreach Specialist attributed this success to educating the community about the program and efficiently managing the workload. The specialist added that facility staff refer veterans to the program, and program staff train local law enforcement monthly, which helped them identify veterans for enrollment.

Meeting Veteran Needs

The Veterans Justice Outreach Specialist stated staff track each veteran's needs in a national homeless database and in the individual's electronic health record. Staff then work with facility and community partners to address any unmet needs, such as financial assistance and substance use treatment.

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

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

[66] 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*.

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."[67] 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.[68]

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).[69] The program did not meet the target in FYs 2021, 2022, or 2023. The staff explained that investors had purchased housing in the area and did not accept rental vouchers, which limited availability. Staff also said difficulty finding landlords willing to rent to veterans with recent evictions, legal issues, no income, or pets created challenges to meeting the measure; therefore, they established relationships with landlords to improve performance.

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).[70] The program did not meet the target in FYs 2021, 2022, or 2023. The Housing and Urban Development–Veterans Affairs Supportive Housing Coordinator told the OIG that program staff sometimes failed to update veterans' employment status in the national homeless database,

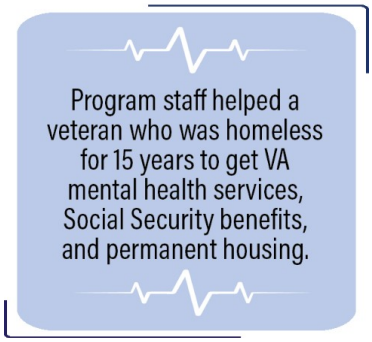


Figure 17. *A Housing and Urban Development–Veterans Affairs Supportive Housing success story.*
Source: OIG interview.

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

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

[69] 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*.

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

which was a factor in missing the targets. The coordinator reminded staff to make the updates.

Program staff informed the OIG that veterans enrolled in the program need transportation, financial and legal assistance; as well as mental health, substance use, and medical treatment. Staff said they assist with transportation and coordinate services with VA programs and community partners to meet these needs.

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 Response

Finding: The OIG observed multiple elevators out of service during the inspection, causing veterans to wait or use stairwells. The OIG witnessed veterans, including one with portable oxygen, struggle to climb the stairs and request assistance from bystanders.

Recommendation 1

The OIG recommends facility leaders ensure all veterans and visitors, including those who require mobility assistance, have safe and accessible pathways to clinical areas during elevator repairs.

__X__ Concur

____ Nonconcur

Target date for completion: May 31, 2025

Director Comments

During the Office of Inspector General-Healthcare Facility Inspection (OIG_HFI) site visit a construction project was in progress to modernize the main bank of elevators at the Oklahoma City VA Health Care System (OKC VAHCS). As mentioned in the report multiple elevators were out of service and OKC VAHCS had implemented multiple strategies to ensure the safety of the veterans and visitors. The elevator modernization project was completed on September 9, 2024. All veteran and visitor elevators are now fully operational.

OKC VAHCS developed new signage that encourages veterans and visitors to please wait for the next elevator when an elevator is out of service. The newly developed signage will be placed on the elevator doors when the elevator is expected to be out of service for more than 24 hours during the week (Monday through Friday). Elevator traffic drastically decreases during the weekend.

OIG Comments

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

Finding: The OIG found medical equipment that lacked preventive maintenance stickers, as well as similar pieces of equipment with inconsistent documentation on the stickers about whether the equipment required maintenance.

Recommendation 2

The OIG recommends facility leaders ensure staff complete and document preventive maintenance for medical equipment.

_X_ Concur

____Nonconcur

Target date for completion: November 30, 2025

Director Comments

To help ensure preventative maintenance for medical equipment is completed timely and documentation is consistent, SOP 138B-5, "Preventative Maintenance Program" was updated. The updated SOP outlines a clear process for when preventative maintenance is due and identifies updated stickers for use on medical equipment. Clinical Engineering will now have a preventative maintenance sticker that states, "No PM Required". The addition of this sticker will reduce confusion for Clinical Engineering and clinical staff throughout the health care system.

Clinical engineering staff are completing rounds throughout the hospital to ensure the new updated stickers are appropriately placed on all medical equipment and expect to be completed with rounding by May 31, 2025. Once medical equipment stickers have been transitioned to the new system, monthly random audits will be completed to ensure updated stickers are present on medical equipment until 6 consecutive months of 90% or higher compliance is met. Numerator will be number of pieces of medical equipment with the correct stickers, denominator will be total number of pieces of medical equipment audited.

OIG Comments

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

Finding: Staff told the OIG that attendees monitored test result communication data at meetings; however, the OIG was unable to verify the Chief of Staff or the Associate Director, Patient Care Services attended the meetings.

Recommendation 3

The OIG recommends the Chief of Staff and the Associate Director, Patient Care Services ensure staff record their attendance at meetings where staff monitor the communication of test result data.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Staff or Deputy Chief of Staff and the Associate Director, Patient Care Services or Deputy Associate Director, Patient Care Services attend the External Peer Review Program meeting where communication of test result data and actions staff take to address deficiencies are reviewed. The External Peer Review Program meetings are TEAMs based meetings and attendance is tracked by meeting organizer.

Attendance tracking of the External Peer Review Program meetings for the past 6 meetings indicates the Chief of Staff or Deputy Chief of Staff and the Associate Director, Patient Care Services or Deputy Associate Director, Patient Care Services were in attendance for 100% of the meetings.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate leaders had completed improvement actions and therefore closed the recommendation as implemented before the report's publication.

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 August 27 through 29, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

[1] The All Employee Survey covered the time frame of October 1, 2020, through September 30, 2023. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in March 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

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

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.

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

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

Appendix C: Facility Photo

Figure C.1. *Similar pieces of equipment with inconsistent preventive maintenance inspection documentation. Source: Photo taken by OIG inspector.*

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 29, 2025

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

Subj: Healthcare Facility Inspection of the VA Oklahoma City Healthcare System in Oklahoma

To: Director, Office of Healthcare Inspections (54HF04)

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Oklahoma City Healthcare System in Oklahoma.
2. Based on a thorough review of the report by VISN 19 Leadership, I concur with the findings, recommendations and submitted action plans of Oklahoma City Healthcare System. As we remain committed to ensuring our Veterans received exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have any questions or additional information is required, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

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

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 23, 2025

From: Director, VA Oklahoma City Healthcare System (635)

Subj: Healthcare Facility Inspection of the VA Oklahoma City Healthcare System in Oklahoma

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

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

(Original signed by:)

Wade Vlosich
Health Care System Director, Oklahoma City VA Health Care System

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