US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Portland Health Care System in Oregon

Healthcare Facility Inspection	24-00609-124	June 4, 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 Portland Health Care System (facility) from July 16 through 18, 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. In interviews, executive leaders identified system shocks as some executive leaders being in their positions for three years or less or in an acting role, VHA's May 2024 guidance that limited hiring, and increased workload to prepare for the new Oracle electronic health record system.[2]

Executive leaders said the COVID-19 pandemic caused staff turnover, and VHA's guidance limited the number of staff they could hire. An executive leader added that leaders implemented alternative work schedules and special salary rates to increase retention, which had been successful.

[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] Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), and VHACO Program Office Leadership, May 31, 2024. "VA's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR…with a new commercial EHR solution." "EHR Modernization – Frequently Asked Questions," Department of Veterans Affairs, accessed May 20, 2024, https://digital.va.gov/ehr-modernization.

Executive leaders also discussed concerns about preparing for the Oracle system. They said staff spent a lot of time getting ready for the implementation, but VHA postponed it several times. To decrease frustration, leaders ensured staff participated in national Oracle implementation councils.

Executive leaders identified personal interactions with staff, town halls, and newsletters as key actions they took to improve communication. They expressed the importance of supervisors getting to know staff personally and understanding their motivation for coming to work and hired a chief wellness officer to support all employees.

Additionally, executive leaders informed the OIG of steps taken to improve veterans' experiences, such as correctly identifying outgoing calls from the facility. Leaders said outgoing calls can appear as scam calls on veterans' phones, which may cause them to not answer. Therefore, they were working on a solution to have calls show as coming from the facility to reduce the missed communication.

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 generally found a clean healthcare environment. However, the OIG noted issues in the emergency department, where staff stored clean and dirty equipment together, and supplies were in uncovered wall cabinets. Facility staff have since corrected the deficiencies by clearing the space of unnecessary equipment and removing the wall cabinets.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility had a system for informing ordering providers about abnormal test results and a defined process for delegating responsibility for test result follow-up.

The OIG found that there were no open recommendations from previously published reports aimed at enhancing the communication of test results. Staff reported leaders were supportive of process improvement projects and described a new process for laboratory staff to reduce blood draw errors.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[3]

The facility had staffing shortages in primary care provider, registered nurse, licensed practical nurse, intermediate care technician, and administrative associate positions. Leaders mentioned that VHA's limited hiring guidance created challenges in recruiting qualified candidates. Therefore, executive leaders said they offered incentives, such as employee educational opportunities and flexible work schedules, to retain current employees.

Leaders remained focused on providing patients timely access to care. Some primary care teams were above 100 percent capacity; therefore, leaders reassigned patients to other teams to balance the workload. Staff described feeling supported and encouraged by leaders to implement process improvement initiatives that led to more efficient and sustainable patient care.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the facility had effective homeless and justice programs, with a strong emphasis on educating internal and external stakeholders about the programs and collaborating with multiple community partners. Homeless program staff described working with state licensing boards to allow outreach social workers to carry and administer Naloxone to veterans experiencing opioid overdoses.[4]

Program leaders and staff identified several barriers in meeting veterans' needs, such as staff vacancies and availability of affordable housing. Despite these challenges, the leaders and staff were working within their resources to address the veterans' needs.

What the OIG Recommended

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

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

[4] "Naloxone is an opioid antagonist that is used to temporarily reverse the effects of an opioid overdose, namely slowed or stopped breathing." "U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose," Department of Health and Human Services, accessed April 8, 2024, https://www.hhs.gov/surgeongeneral/advisory-on-naloxone.

VA Comments and OIG Response

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

JULIE KROVIAK, 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 Portland Health Care System
Portland, Oregon
Level 1a-High Complexity
Multnomah County
Hospital Referral Region: Portland

Description of Community

POPULATION

Female **2,018,228**	Male **1,985,522**
Veteran Female **26,533**	Veteran Male **227,507**

Homeless - State **17,959**
Homeless Veteran -State **1,460**

MEDIAN INCOME

$63,088

EDUCATION

91% Completed High School
62% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **163**

SUBSTANCE USE

28.9% Driving Deaths Involving Alcohol
20.6% Excessive Drinking
1,094 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	1,341,538
Work at Home	177,601
Carpool	175,911
Public Transportation	81,864
Walk to Work	62,734
Other Means	54,133

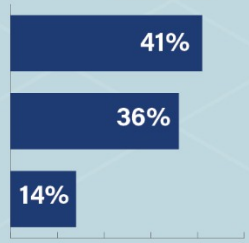
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**38 Minutes, 32 Miles**
Specialty Care	**93 Minutes, 81 Miles**
Tertiary Care	**98 Minutes, 87 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **27,461**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

20,367

433 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.06 Days

30-DAY READMISSION RATE

10%

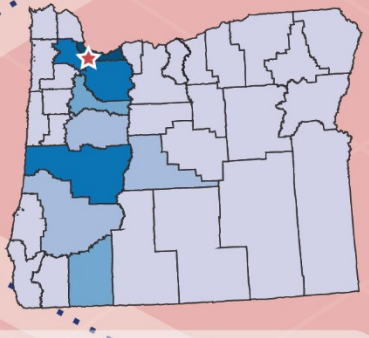
SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
26	50

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	91K
Unique Patients VA Care	81K
Unique Patients Non-VA Care	45K



COMMUNITY CARE COSTS

Unique Patient $31,222	Outpatient Visit $365
Line Item $1,138	Bed Day of Care $476

STAFF RETENTION

Onboard Employees Stay <1 Yr	7.72%
Facility Total Loss Rate	12.66%
Facility Retire Rate	2.77%
Facility Quit Rate	9.05%
Facility Termination Rate	0.72%

VETERAN POPULATION

0.06% 2.88% 5.69% 8.50% 11.31% 14.11%

★ **VA MEDICAL CENTER**

The VA Portland Health Care System includes the Portland VA Medical Center and the Vancouver VA Medical Center (not shown).

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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

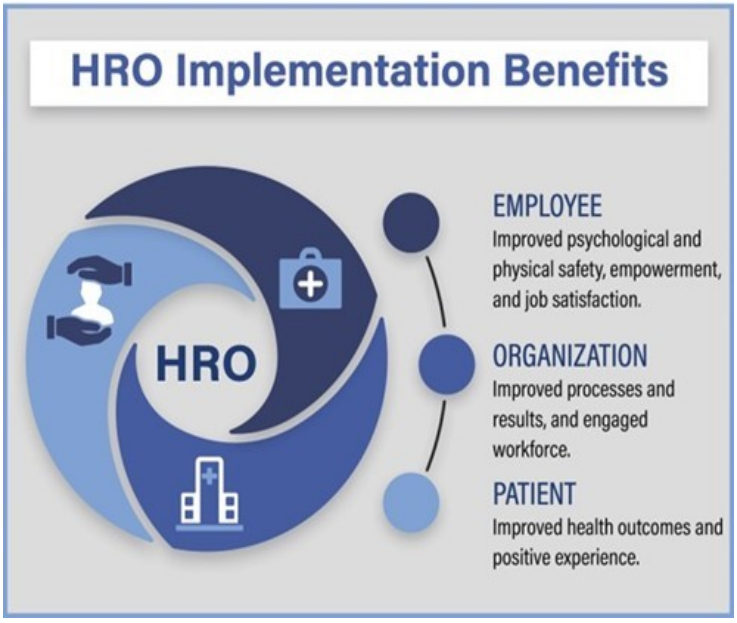


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

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.

[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).

Content Domains

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

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

The VA Portland Health Care System (facility) includes the Portland VA Medical Center, which opened in 1932, and the Vancouver VA Medical Center, which began providing services in 1946. At the time of the OIG inspection, the facility's executive leaders consisted of the Medical Center Director, Chief of Staff, Deputy Director, Acting Associate Director, and Deputy Director for Patient Care Services. The facility had 296 operating beds (191 hospital, 76 community living center, and 29 domiciliary beds), and a fiscal year (FY) 2023 budget of approximately $1.3 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 November 13, 2024, https://www.va.gov/VA_Community_Living_Centers. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 13, 2024, https://www.va.gov/homeless/dchv.

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

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

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

System Shocks

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

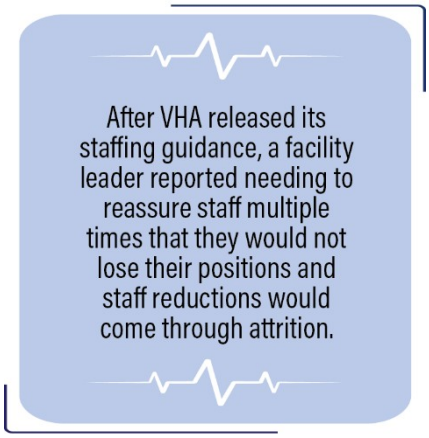


Figure 4. *Facility systems shocks. Source: OIG interview with facility leaders.*

In interviews, leaders identified three system shocks:

- Two of the five executive leaders had been in their positions for three years or less, and one was in an acting role.
- VHA issued hiring and attrition guidance in May 2024.
- Staff had to prepare for the new Oracle electronic health record system.[19]

Most of the staff who responded to the OIG questionnaire identified turnover in key leadership positions as the facility's primary system shock. The Deputy Director started in 2020, the Deputy Director for Patient Care Services in 2021, and the Medical Center Director in 2022. The most tenured leader, the Chief of Staff, was permanently assigned in 2018, while the newest, the Acting Associate Director, began less than a month before the OIG inspection. Further, the associate director role had not been permanently staffed since May 2022. Leaders explained there had been significant turnover in leadership positions across many areas of the facility in

[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] The Under Secretary for Health published a memo that detailed VHA's staff hiring and attrition plan and provided guidance for reducing "cumulative staff" in fiscal year 2025. Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO Program Office Leadership, May 31, 2024. "VA's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR…with a new commercial EHR solution." "EHR Modernization – Frequently Asked Questions," Department of Veterans Affairs, accessed May 20, 2024, https://digital.va.gov/ehr-modernization.

recent years and identified burnout due to the COVID-19 pandemic and retirement as the main reasons leaders left.

During an interview, executive leaders discussed how VHA's hiring and attrition guidance affected staffing levels. First, approximately 300 staff left during the COVID-19 pandemic for various reasons. The loss of so many staff members increased workload for the remaining staff, which eventually led to burnout (stress due to overwork). To reduce stress, facility leaders offered incentives like alternative work schedules and special salary rates, which were successful. Then, when the PACT Act was implemented, VHA leaders suggested increased hiring to meet the anticipated influx of new patients. However, due to VHA's memorandum, facility leaders paused hiring efforts.

Executive leaders also expressed concerns about the workload placed on staff preparing for the Oracle electronic health record system's implementation. VHA scheduled several dates for the implementation but rescheduled or postponed them each time. Leaders said the numerous date changes were time- and resource-intensive and caused frustration among staff. The Chief of Staff explained that facility leaders attempted to mitigate this shock by ensuring staff participated on national Oracle implementation councils to provide medical knowledge and input to VHA.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22] The OIG reviewed VA's All Employee Survey data from FYs 2021 to 2023 and interviewed leaders to determine how they demonstrated transparency,

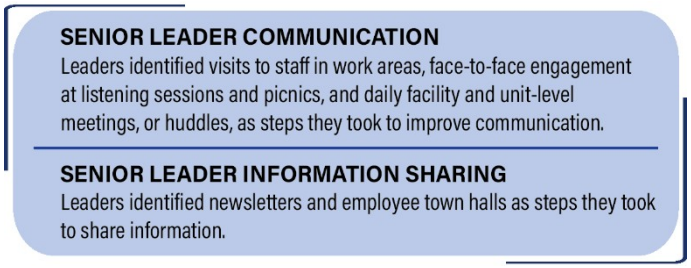


Figure 5. *Leader communication with staff. Source: OIG interview with facility leaders.*

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

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

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

communicated with staff, and shared information.[23]

VA survey scores showed staff perceived executive leader communication, transparency, and information sharing positively. The Chief of Staff acknowledged finding the right method to communicate could be challenging. Leaders said frontline supervisors and service chiefs had important roles in the communication process; specifically, they can present information from the executive leaders to staff in their area in relevant and relatable terms.

Leaders discussed several ways they improved communication and shared information, such as visits to work areas, town halls, and human resources newsletters. Leaders also identified several barriers to communication: staff misunderstanding the intent and tone of emails, and the lack of coordinated messages from the VA Central Office and national VHA program offices about changes like hiring and attrition guidance.[24] To overcome these barriers, leaders emphasized speaking on the phone or in person after email miscommunication and ensuring consistent messaging from both within and outside the facility. Leaders measured the success of these actions through increased staff participation in town halls and meetings, fewer repeated issues brought up by staff during HRO tiered huddles, and VA survey results that did not include communication among the top three areas needing improvement.[25]

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.

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

[24] VHA has 13 national program offices that cover broad areas of the health system such as finance, patient safety, and quality. "VHA Program Offices," Department of Veterans Affairs, accessed October 21, 2024, https://www.va.gov/health/orgs.asp.

[25] Tiered huddles, involving frontline staff to senior leaders, are brief, focused meetings used to share information, identify possible problems, address staffing levels, and allocate resources. Naseema B. Merchant et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine 188*, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000/.

[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 Best Places to Work survey score decreased in FY 2022, which leaders attributed to executive leader changes, employee turnover, increased workload, and exhaustion from the height of the COVID-19 pandemic.[28] Leaders expressed the importance of supervisors getting to know employees personally, understanding their motivation for coming to work, and working with union partners as key steps to improving employee satisfaction. Of note, leaders pointed to the facility hiring a chief wellness officer to support all employees. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. Most questionnaire respondents indicated they felt comfortable reporting patient and safety concerns.

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.

The Patient Advocate's response to an OIG questionnaire indicated staff were not responsive to veterans' concerns. In an interview, the Deputy Director said some veterans had complex concerns that required resources from multiple departments and coordinating the care for those veterans may have contributed to the perception that staff were not responsive. Additionally, the leader said they would never dismiss veterans' concerns.

Also, executive leaders mentioned that a barrier to responding and addressing veterans' complaints was the facility's phone system. They said outgoing calls from the facility can look like scam calls on recipients' phones, and they were working on how to have the calls show as coming from the facility to reduce missed communication with veterans.

The OIG distributed a questionnaire to one local VSO but did not receive a response. Despite the lack of response, the Medical Center Director stated executive leaders had strong relationships with VSOs. Specifically, leaders previously hosted the National Veterans Wheelchair Games; the event was a successful collaboration between VSOs and the facility.[31]

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[28] The Best Places to Work score "is a weighted average of job satisfaction, organization satisfaction, and whether people would recommend VA as a good place to work." "VA All Employee Survey," Department of Veterans Affairs, accessed August 6, 2024, https://www.datahub.va.gov/VA-All-Employee-Survey-AES.

[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] "The National Veterans Wheelchair Games is the world's largest annual wheelchair sports and rehabilitation event solely for military veterans." "Mission & History," National Veterans Wheelchair Games, accessed February 3, 2025, https://wheelchairgames.org/about/mission-history/.

The Medical Center Director reported meeting VSO representatives monthly at both the Portland and Vancouver sites, attending various community events with veterans and VSOs, and holding face-to-face and virtual veteran town halls at all the outpatient clinics. Leaders also said VSOs requested and were given space at the facility to support veterans on-site. Additionally, the Medical Center Director and Deputy Director said they receive ongoing feedback from VSOs and congressional partners as part of two-way communication to address veterans' issues or specific concerns.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[32] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints, (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 6. *Portland VA Medical Center of the VA Portland Health Care System.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and

[32] VHA Directive 1608(1).

[33] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

Transit and Parking

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

The OIG used a navigation link on the facility's website and a phone application to obtain accurate directions to the facility. The facility has multiple signs directing veterans to parking areas, buildings, and the main entrance.

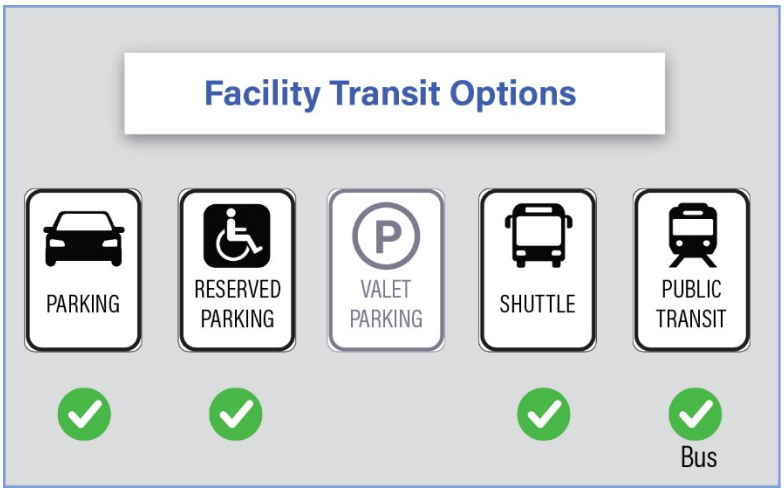

Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

The OIG observed that parking lots have accessible spaces for individuals with disabilities and adequate lighting and pathways. Although there were no police emergency call buttons, the OIG saw emergency telephones at parking lot entry points. The facility also has bus and shuttle services to transport veterans between the Portland and Vancouver medical centers.

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

Main Entrance

Figure 8. *Facility front entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[35]

The OIG observed clear signage for the facility's main entrance, parking lots, and walkways. The entrance had power-assisted revolving and sliding doors, allowing access for individuals with disabilities. The entrance also featured an extended canopy above the doors for shelter, and detectable changes in flooring to assist visually impaired veterans.[36]

Additionally, the main entrance had multiple windows that allowed natural lighting, a spacious lobby that included a volunteer-staffed information desk, an adjacent café stand, ample seating areas, and multiple wheelchairs for veterans who need assistance to their destination. The OIG's overall impression was of a clean, functional, and welcoming space.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[37]

While no printed maps of the facility were available, the OIG observed directories in the entrance lobby and signs on walls and hallway intersections throughout the facility to direct veterans to their destination. The OIG also noted volunteers who escort veterans to their appointment locations or provide verbal directions.

[35] 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*.

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

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[38] The OIG observed braille floor numbers outside each elevator, but no audio instructions or cues available. However, veterans generally did not navigate independently because volunteers were readily available to assist as needed.

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

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.[39]

The OIG interviewed the Clinical Director of Primary Care and a Quality Safety Value Nurse Consultant, who described the facility's screening processes. Leaders had appointed two toxic exposure screening navigators within a week prior to the OIG site visit, both performing the role as an additional duty. The clinical director and nurse consultant said a licensed independent practitioner, nurse, or intermediate care technician screen veterans during primary care or specialty care visits. When veterans report a toxic exposure or are unsure of their exposure status, licensed independent practitioners perform secondary screenings and refer them to compensation and pension providers, if needed. The clinical director added there were no access, space, or wait time barriers to staff completing 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

[38] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

[39] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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 Chief of Occupational Safety and the Deputy Director stated that in FY 2023, the top three deficiencies identified during environment of care inspections were damaged furniture, paper items taped to walls, and picture frames not adequately anchored on walls. However, leaders also said the prior Comprehensive Environment of Care Coordinator left the position and did not initiate a performance improvement plan to address these deficiencies. The Chief of Occupational Safety reported taking on the coordinator's responsibilities, and at the time of the site visit, had ensured staff entered work orders to replace damaged furniture, removed the paper items from walls, and anchored the picture frames.

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 conducted physical inspections of four areas: the emergency department, the intensive care unit, a medical-surgical unit, and the primary care clinic. The OIG observed that overall, the facility was clean and well maintained, but noted multiple lift devices, stretchers, and wheelchairs in the area where external emergency responders enter the facility. In addition, the OIG noted clean and dirty equipment stored together, and supplies kept in open wall cabinets that could be at risk for contamination. Facility staff corrected the deficiencies by removing unnecessary equipment while the OIG was on-site, and the wall cabinets after the site visit.

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.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[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 facility had processes for staff to communicate test results to ordering providers and patients, identify a backup provider when the ordering provider was unavailable, and indicate which abnormal test results required follow-up. Leaders said they monitor how promptly diagnostic providers communicate test results to ordering providers and how timely ordering providers relay these results to patients.

Action Plan Implementation and Sustainability

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

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[43] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The facility had no open recommendations from the previous comprehensive healthcare inspection report over the past three years.[44] Based on discussions with a facility leader and quality management staff, the OIG discovered that staff monitored compliance with oversight recommendations in monthly Accreditation and Regulatory Oversight Committee meetings. The committee ensures staff implement and sustain corrective actions from recommendations and reports to the Quality and Safety Council. Staff said during the committee meetings, they discuss

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

[44] VA OIG, *Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon*, Report No. 20-01257-180, July 13, 2021.

the action plans, and if they identify issues with sustained improvement, they request support from executive leaders.

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.[45] 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.[46] 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 Staff and quality management staff reported facility leaders supported process improvement projects, and there were no barriers to staff initiating such projects. For instance, laboratory staff had begun a new project aimed to prevent delays in care caused by blood collection errors, such as staff using the wrong tube or collecting an inaccurate volume. At the completion of the project, executive leaders hope the results will help them identify possible reasons for the errors.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[47] 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.[48] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

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

[46] VHA Directive 1050.01(1).

[47] 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.

[48] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

staffing shortages.[49] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, the facility had staffing shortages among primary care providers, registered nurses, licensed practical nurses, intermediate care technicians, and administrative associates. In an interview, facility leaders stated that although vacancies existed in multiple locations, North Coast and The Dalles had significant challenges with recruitment due to their rural locations. Also, leaders mentioned that fewer people were moving to those areas due to the high cost of living, which contributed to difficulties recruiting qualified candidates.

In addition, the leaders told the OIG that another recruitment challenge was VHA's hiring and attrition guidance, which led to a pause in hiring.[50] Leaders focused on retention by offering current employees incentives, such as increased nurses' salaries, employee educational opportunities, and flexible work schedules.

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.[51] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[52]

The OIG found panel sizes were generally a concern for leaders and primary care staff, who expressed feelings of burnout and an overwhelming workload. At the time of the OIG site visit, a staff member told the OIG that 10 of 76 primary care panels exceeded VHA's recommended capacity. To help with workload and ensure prompt access to high-quality care, leaders assessed panel sizes and staffing at all primary care locations and reassigned patients between locations to ensure balanced panel sizes.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[53] Continuous process improvement is also one of the three

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

[50] Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO Program Office Leadership.

[51] "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).

[52] VHA Directive 1406(1).

[53] VHA Handbook 1101.10(2).

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

Primary care staff indicated they found leaders to be supportive, encouraging of process improvement ideas, and collaborative in improving efficiency and team functioning. They highlighted a successful process improvement initiative in which patients monitored their blood pressure at home and maintained the records. Staff said they met the initiative's goals: patients successfully maintained blood pressure logs and provided them to their care teams.

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 the PACT Act did not correlate with an increase in wait times for veterans seeking appointments and did not disrupt primary care workflows. At the time of the site visit, appointment wait times averaged 23 days for new patients, slightly longer than VHA's goal of 20 days.

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.[54]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[55] VA uses the Department of

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

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

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

The facility's program did not meet the HCHV5 target in FYs 2021 through 2023, but did meet it in quarter two of FY 2024.[57] The Director Community Reintegration Services attributed not meeting the target to program staff misunderstanding the requirement to do an intake assessment and enter information into the program database for each veteran who contacted them.[58] Program leaders then trained staff on intake assessments, which improved the HCHV5 metric by quarter two of FY 2024. The director also voiced concerns about the accuracy of the point-in-time count because staff did not count veterans in certain areas in Portland, such as forests, due to safety concerns.

The director told the OIG that program staff identified veterans through community outreach and referrals from the national homeless hotline call center, facility and community providers, and the Community Resource and Referral Center's walk-in clinic.

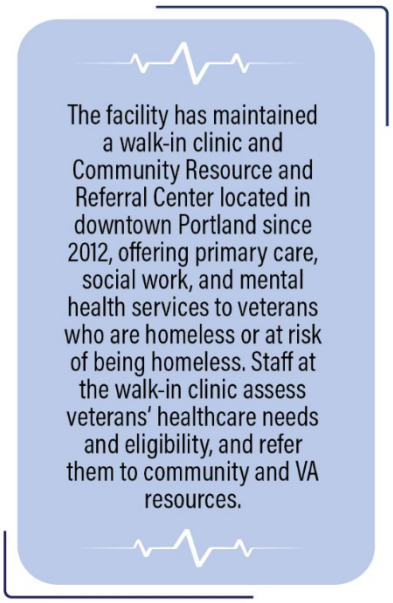

Figure 11. *Community Resource and Referral Center.*
Source: OIG analysis of documents and interviews.

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

[57] VHA sets escalating targets for HCHV5 at the facility level each year with the goal to reach 50 percent or above by the end of quarter 2 and 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*. The facility's HCHV5 measure reached 65.27 percent for FY 2021, 68.06 for FY 2022, 67.91 percent for FY 2023, and 55.94 percent for quarter two of FY 2024.

[58] The facility's homeless programs, including HCHV, were identified as Community Reintegration Services and situated in the mental health division.

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]

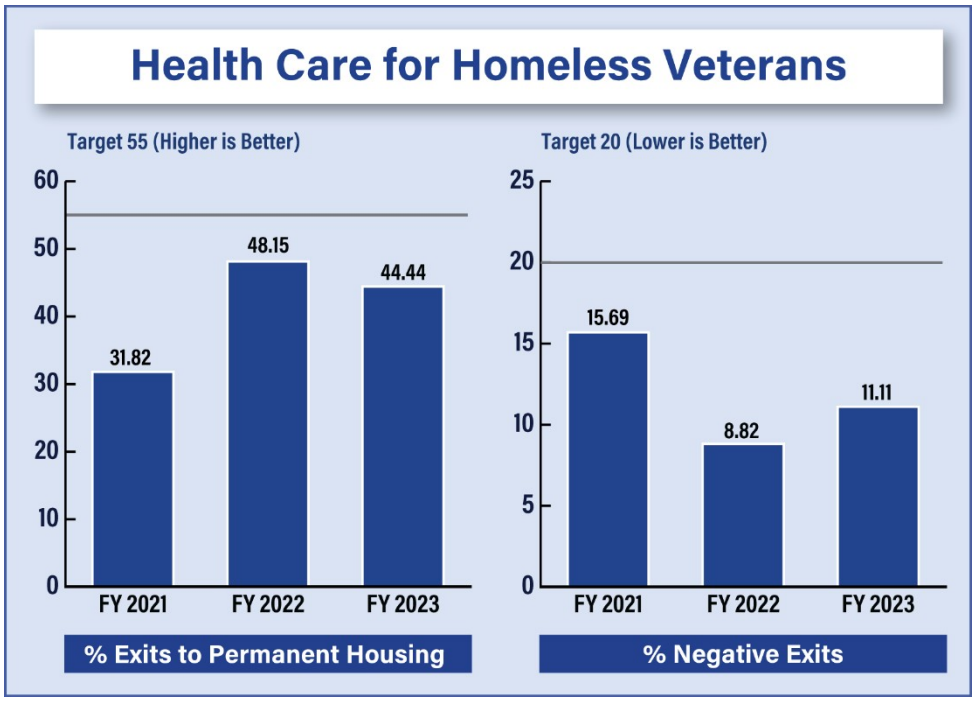

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The OIG noted the facility did not meet the HCHV1 target but did meet the HCHV2 target each year from FY 2021 through FY 2023.[60] The Director Community Reintegration Services attributed missing the HCHV1 target to program staff not moving veterans timely from transitional (temporary) housing to permanent housing after admission to the program.[61] Despite missing the target, program staff provided documentation to the OIG that showed 60 percent of

[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] The facility's HCHV1 measure reached 31.82 percent for FY 2021, 48.15 percent for FY 2022, and 44.44 percent for FY 2023. The facility's HCHV2 measure reached 15.69 percent for FY 2021, 8.82 percent for FY 2022, and 11.11 percent for FY 2023.

[61] "HCHV CERS [Contracted Residential Services] and LDSH [Low Demand Safe Haven] programs are designed to provide low-demand housing services to Veterans as they transition to other programs or to PH [permanent housing]." Veterans are excluded from the HCHV1 denominator if transferred to a transitional housing program after staying in the Contracted Residential Services program less than 31 days. VHA Homeless Programs Office, *Technical Manual, FY 2023 Homeless Performance Measures.*

the veterans who did not exit to permanent housing in FY 2023 had acquired permanent housing by the time of the site visit. The director attributed meeting the HCHV2 target to the positive work of program staff.

Additionally, the director explained that program staff foster community partnerships and work with state licensing boards to develop procedures for treating veterans experiencing a potential overdose. The director highlighted a recent collaboration with the Washington and Oregon state licensing boards. The boards allowed community-based outreach social workers to carry and administer Naloxone to homeless veterans experiencing a known or suspected opioid overdose.[62]

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 met the target for FY 2023. At the time of the site visit, program staff consisted of three social workers who provided services to 23 jails and five veterans treatment courts in the service area.[66] In an interview, program staff attributed meeting the target to establishing relationships with jail staff and veterans, and ensuring staff entered homeless veterans' admission assessments and demographic information into the program

[62] "Naloxone is an opioid antagonist that is used to temporarily reverse the effects of an opioid overdose, namely slowed or stopped breathing." "U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose," Department of Health and Human Services, accessed April 8, 2024, https://www.hhs.gov/surgeongeneral/advisory-on-naloxone.

[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] "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. Program staff explained that a Veterans Integrated Service Network employee provides outreach and services to veterans in 12 prisons in the facility's service area.

database. Also, the OIG learned that staff identify veterans for program enrollment through the Veterans Reentry Search Service, self-referral, and referral from community partners.[67]

Meeting Veteran Needs

In response to an OIG-administered questionnaire, program staff described treatment objectives for veterans enrolled in the program as individualized based on clinical needs. The staff told the OIG they educate veterans, facility staff, attorneys, judges, and jail and veterans treatment court staff about the program. They also train law enforcement to identify veterans in the justice system who could benefit from program services.

Additionally, program staff explained they participate in veterans treatment court meetings with the court staff, judges, and attorneys to connect veterans to services including VA medical care. In the months prior to the OIG site visit, program staff were actively involved in developing a new veterans treatment court in the largest county of the facility's service area. Program staff also connect enrolled veterans with VSOs, substance abuse treatment programs, and legal and housing resources according to individual needs.

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

[67] The Veterans Reentry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military." "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) – Terms and Conditions of Use," Department of Veterans Affairs, accessed January 30, 2025, https://vrss.va.gov. (This website is not publicly accessible.)

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

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

to the facility that are being used by veterans or their families (performance measure HMLS3).[70] The facility did not meet the HMLS3 target from FY 2021 through FY 2023. The program staff said they collaborate with 14 public housing authorities in southwest Washington and northwest Oregon to provide housing vouchers to homeless veterans.[71] The Community Reintegration Services Director discussed program and public housing authority staff vacancies and limited available housing as program challenges.

Due to limited availability coupled with a highly competitive housing market, when veterans submit their housing application, they must have immediate funds to cover application fees. The director said leaders partner with a nonprofit agency that provides funds to veterans with limited financial resources to assist with the application fees.

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).[72] The facility met the target in FYs 2021 through 2023. According to program staff, the program met the goal in part due to effectively collecting employment data.

Program staff also discussed outreach efforts focused on meeting veterans needs through case management and building strong relationships with community partners and public housing authorities. Describing the community partnerships as imperative, the Director Community Reintegration Services said they provided resources, such as temporary financial assistance to resolve overdue rent, as well as furniture, food boxes, and transportation to nonmedical appointments.

Additionally, in an OIG questionnaire, staff reported they frequently conducted outreach to prospective landlords to identify available units. Staff said the facility maintained two project-based units that housed 79 elderly veterans on the Vancouver site, with one registered nurse, one licensed practical nurse, and one occupational therapist to provide care.[73] Program staff noted

[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.*

[71] Department of Housing and Urban Development, "Housing Choice Vouchers Fact Sheet." The Housing Choice Voucher Program is a rental subsidy program. HUD provides federal funding to public housing authorities, who in turn pay housing subsidies to landlords on behalf of the program's participants.

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

[73] Project-based vouchers (PBV) "are a component of the [Public Housing Agency's] housing support program. Under the PBV program, a Public Housing Agency (PHA) enters into an assistance contract with the owner of a property for a specified number of units and for a specified term." VHA Directive 1162.05(2), *Housing and Urban Development Department of Veterans Affairs Supportive Housing Program,* June 29, 2017, amended June 24, 2024.

this team provided excellent services but indicated more clinical staff were needed to meet the needs of veterans in the program.

Conclusion

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

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to one VSO. 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 July 16 through 18, 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 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 30, 2025

From: Director, VA Northwest Health Network (10N20)

Subj: Healthcare Facility Inspection of VA Portland Health Care System in Oregon

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

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

1. Thank you for the opportunity to provide a response to the draft report, Healthcare Facility Inspection of VA Portland Health Care System in Oregon.
2. I concur with the report as written.

(Original signed by:)

Teresa D. Boyd

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2025

From: Medical Center Director, VA Portland Health Care System (648)

Subj: Healthcare Facility Inspection of the VA Portland Health Care System in Oregon

To: Network Director, VA Northwest Health Network (10N20)

1. I have received and reviewed the OIG Healthcare Facility Inspection draft report for the VA Portland Health Care System.
2. Although there were no recommendations in the report, we are committed to continually improving of the quality of care provided by the VA Portland Health Care System.

(Original signed by:)

Karla M. Azcuy
Interim Medical Center Director
VA Portland Health Care System

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