US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Hershel "Woody" Williams VA Medical Center in Huntington, West Virginia

Healthcare Facility Inspection	24-00616-139	June 17, 2025

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

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the Hershel "Woody" Williams VA Medical Center (facility) from September 9 through 12, 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 an interview, executive leaders identified turnover in primary care provider positions at two outpatient clinics and the COVID-19 pandemic as system shocks. Leaders responded to the loss of multiple providers by using facility and Veterans Integrated Service Network services to provide patient care while hiring new providers.[2] To address the pandemic, leaders changed how staff provided care; they reallocated staff to meet different needs, increased virtual visits, and offered maximum work schedule flexibilities. Leaders stated staff worked together as a team to meet the mission.

The OIG also reviewed the facility's VA All Employee Survey results and found scores had improved across various areas, including communication and information sharing, transparency,

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

supervisory trust, and psychological safety.[3] The facility's scores were higher than VHA averages across these questions and years; in fact, executive leaders reported the facility has ranked as one of VHA's best places to work for the past few years. Leaders attributed the results to the facility's strong culture, effective communication, and ongoing commitment to improving scores.

Leaders emphasized the importance of ensuring buy-in from employees and taking pride in the work and the care provided to veterans. The facility's focus on caring for, honoring, and serving veterans was evident in several ways, including daily Pledge of Allegiance recitations and the Director's birthday celebrations when a veteran turns 100 years old. Additionally, during the New Employee Academy (scheduled activities included in the new employees' onboarding process), the Director talks about VA's core mission and values, and the employees also hear directly from veterans about the care they receive. To maintain communication, leaders hold town halls, walk around the facility, and attend unit-level meetings to ensure employees have opportunities to ask questions and receive timely information.

The OIG administered a questionnaire prior to the site visit. Respondents reported leaders share information that is clear and useful, and the culture of the facility is moving in the right direction. Also, respondents identified the VA mission as the main reason they stay at the facility, and indicated they feel empowered to suggest changes for further improvements.

The OIG also administered questionnaires to veterans service organizations and the facility's patient advocates. Respondents to both reported they can provide feedback to leaders about veterans' care, and leaders are responsive to any concerns. The Director shared that they established a Fisher House in response to a suggestion from a veteran's spouse.[4] Through interviews, the OIG found that leaders focused on the mission to serve, honor, and care for veterans.

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

[3] The VA All Employee Survey (AES) "is an annual, voluntary 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. "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.

[4] A Fisher House is a no-cost place for families and caregivers to stay while a veteran receives care at a VA facility. "VHA Social Work, Fisher House Program," Department of Veterans Affairs, accessed October 18, 2024, https://www.socialwork.va.gov/fisher.asp.

navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine whether there were recurring issues.

The OIG found the facility provided a welcoming main entrance with sufficient parking; valet parking, shuttle service, and public transportation were also available. Inside the main entrance was an information desk run by volunteers who answered questions and escorted veterans as needed, a café, and a small emergency department triage area. Wheelchairs were available at the main entrance, but many had torn arm rests (which could prevent proper disinfection) or mechanical issues (making them unusable). Also, although the information desk volunteers and patient advocate staff were eager to assist veterans, they were unaware of how to access the contracted American Sign Language interpreter service.

The facility had clear exit paths and secured supplies and medications; however, there was unsecured protected patient information, expired food in storage areas, and dirty floors. According to the Environment of Care Committee chairperson, staff vacancies in Environmental Management Services may have contributed to the dirty floors. The OIG made one recommendation concerning the environment of care.

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 noted the facility had processes to identify a designee to receive the test results when an ordering provider was unavailable or had left the facility.

Staff regularly review data related to provider notification of test results. Leaders identified challenges, including providers waiting until the next appointment to communicate test results to patients, which could delay communication if the appointment is canceled or rescheduled, and the volume of alerts received daily in the electronic health record system.[5] Leaders reported addressing the alerts by educating providers on how best to manage them.

At the time of the inspection, the facility had no open recommendations. The Chief of Staff and quality management staff said they monitor and report on action plans for open recommendations, as well as for some closed recommendations to ensure staff sustained corrective actions. The Chief of Staff and quality management staff described several improved processes for ensuring staff scan care in the community results into patients' electronic health

[5] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

records in a timely manner.[6] The OIG did not identify any barriers to long-term improvements related to general patient safety.

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 affected the primary care delivery structure and new patient appointment wait times.[7]

Although panels (patients assigned to a primary care team) did not exceed VHA's expected size, the OIG found wait times for new patients had increased because of staff turnover, as well as patients' complex care needs that resulted in more frequent appointments.[8] Leaders reported being aware of the increased wait times and believed they would decrease with the hiring of new providers.

Primary care staff identified view alerts and consult management as issues affecting efficiency and team functioning. They reported feeling anxious about the number of alerts received daily and feared missing something important due to the volume. Leaders said they are reducing the number of alerts.

Staff also identified a consult management issue related to delays in staff obtaining care in the community test results and scanning them into patients' electronic health records. Leaders said they hired additional staff, purchased more scanners, and implemented a new standard operating procedure so providers receive the results and notify patients timely.

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 and Veterans Justice programs, with a strong emphasis on outreach and connections with multiple community partners, that met veterans' needs. However, the Homeless Program Coordinator and program staff identified two barriers: limited affordable

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

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

[8] 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. "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).

housing and public transportation. In response, homeless program staff transport veterans to medical and housing appointments.

Program staff also spoke about several innovative practices occurring at the facility: collaboration between the Veterans Justice Program and the West Virginia Department of Motor Vehicles to help veterans regain their driver’s licenses. They also have partnerships set up by the Housing and Urban Development–Veterans Affairs Supportive Housing program that offer veterans a pathway to permanent housing.

What the OIG Recommended

The OIG recommends the facility Director ensures leaders provide a safe and clean environment of care for veterans, including having adequate staff to clean floors, protecting patient information, and ensuring food is dated and has not expired.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, and the response within the body of the report for the full text of the directors’ comments). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, 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

Hershel "Woody" Williams VA Medical Center
Huntington, West Virginia
Level 1c-High Complexity
Wayne County
Hospital Referral Region: Huntington

Description of Community

POPULATION

Female **332,611**	Male **322,957**
Veteran Female **3,170**	Veteran Male **38,834**

Homeless - State **1,375**
Homeless Veteran -State **122**

MEDIAN INCOME

$44,302

EDUCATION

84% Completed High School
53% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **136**

SUBSTANCE USE

24.9% Driving Deaths Involving Alcohol
15.0% Excessive Drinking
578 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	206,630
Carpool	19,815
Work at Home	8,882
Walk to Work	4,839
Other Means	1,663
Public Transportation	861

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**28.5 Minutes, 24 Miles**
Specialty Care	**53 Minutes, 44 Miles**
Tertiary Care	**134.5 Minutes, 134 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **8,200**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	31%
<65 without Health Insurance	12%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

7,020

27 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.32 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
25	42

Health of the Facility

UNIQUE PATIENTS

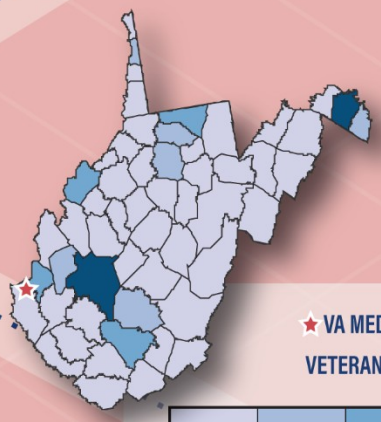
Unique Patients VA and Non-VA Care	29K
Unique Patients VA Care	26K
Unique Patients Non-VA Care	16K

COMMUNITY CARE COSTS

Unique Patient $32,253	Outpatient Visit $334
Line Item $1,005	Bed Day of Care $380

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.75%
Facility Total Loss Rate	11.26%
Facility Retire Rate	2.35%
Facility Quit Rate	7.84%
Facility Termination Rate	0.87%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.37% 2.12% 3.86% 5.59% 7.33% 9.06%

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

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

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

High Reliability Organization Framework

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

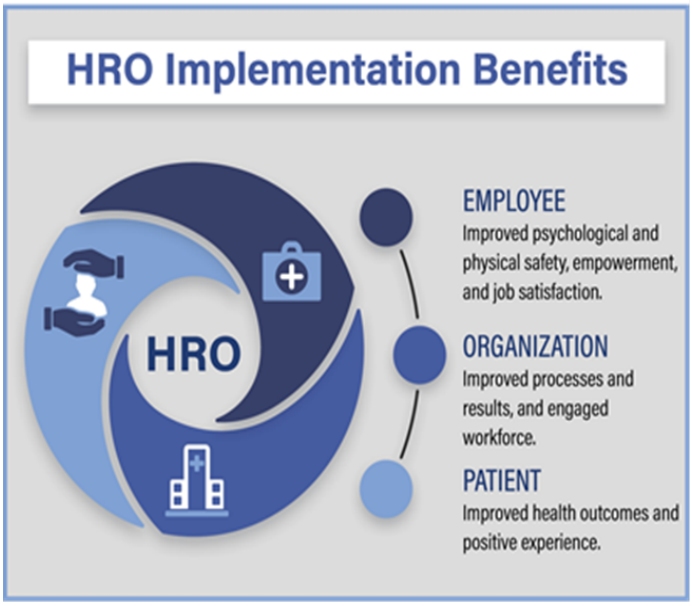


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The

[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.

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.

[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 Hershel "Woody" Williams VA Medical Center (facility) originally opened in 1932 and received its current name in 2018. The facility provides care at the main site in Huntington, as well as five outpatient clinics.[13] At the time of the inspection, the facility's executive leaders consisted of the facility Director, Associate Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. The executive leadership team had been working together since September 2023, when the Associate Medical Center Director was hired. The facility provided care to 28,336 patients, had 95 operating beds (80 inpatient hospital and 15 domiciliary), and a fiscal year (FY) 2023 medical care budget of $535,712,007.[14]

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

[13] The five outpatient clinics are located in Prestonsburg, Kentucky; Gallipolis, Ohio; and Williamson, Huntington, and South Charleston, West Virginia.

[14] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 10, 2024, https://www.va.gov/homeless/dchv.asp.

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

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

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

System Shocks

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

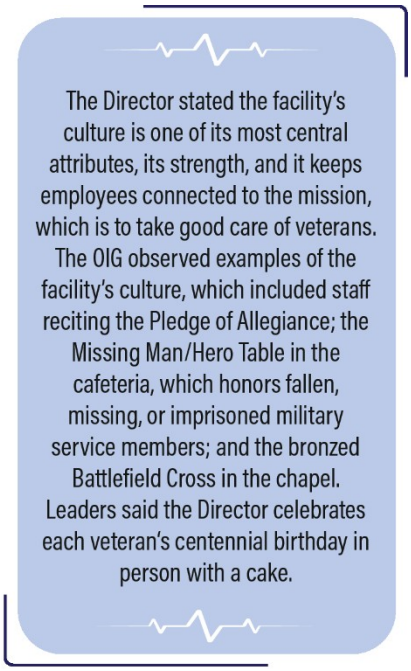


Figure 4. *Facility's unique attributes. Source: OIG interview with facility leaders.*

During an interview, executive leaders discussed several system shocks, including primary care provider turnover in two outpatient clinics (Prestonsburg and Charleston) and the COVID-19 pandemic. Leaders said most of the providers left around the same time due to retirements or transfers to another location. They explained that when the providers left the Prestonsburg clinic, the Chief and Assistant Chief for Ambulatory Care and clinical staff covered the positions to ensure veterans received timely care. The Charleston clinic relied on the Veterans Integrated Service Network (VISN) Primary Care Clinical Resource Hub to assist in providing timely care.[20] Leaders further reported recruitment challenges in both areas, due to Prestonsburg's rural location and competition with other facilities in Charleston.

Despite the challenges, leaders said they were able to hire providers, increase their salaries, and offer retention bonuses. Leaders added they have either hired providers to fill the vacancies or extended job offers.

---

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

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

[20] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/. "Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed January 1, 2025, https://www.patientcare.va.gov/CRH.

In describing COVID-19's impact on the organization, leaders said staff established a clinic to treat patients with symptoms, worked overtime to administer vaccines, and shared ideas on how to improve efficiency in the clinics. Staff also shifted from previously assigned areas and received training to work on the inpatient units. In addition, the facility increased the number of virtual visits available through telehealth services, offered maximum flexibilities with work schedules to meet staff's needs, and used staff from other VA facilities to assist as needed.[21] Leaders stated they listened to staff's ideas, showed appreciation for their flexibility, and worked together as a team to meet VA's mission to serve veterans. The OIG determined leaders had established a culture that emphasizes HRO principles and embraces VA's mission, and responded effectively to each of the identified system shocks.

Leadership Communication

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

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

The OIG found that scores for senior leaders in these areas increased between FYs 2021 and 2023, and scores were higher than VHA averages. During an interview, executive leaders said they were aware of the survey scores and improved their efforts to ensure frequent and transparent communication with all employees; this included conducting town halls, visiting staff

[21] "VA Telehealth Services gives you access to the care you need, when and where you need it." "VA Telehealth," Department of Veterans Affairs, accessed October 19, 2024, https://telehealth.va.gov.

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

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

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

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

throughout the medical center and outpatient clinics, and attending unit-level employee meetings to ensure everyone has opportunities to ask questions and receive timely information.

Leaders also said employees receive Good Catch Awards and provide feedback, which indicates improved communication between leaders and employees.[26] In the OIG-administered questionnaire, employees largely agreed or strongly agreed that executive leaders had changed how they communicate information, and the information was clear and useful.

[26] "The 'Good Catch Award' recognizes employees who report close calls or other patient safety concerns." "VHA National Center for Patient Safety, VA Boston Displays Transparency in Patient Safety," Department of Veterans Affairs, accessed November 6, 2023, https://www.patientsafety.va.gov/VA_Boston_Displays_Transparency_in_Patient_Safety.asp.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

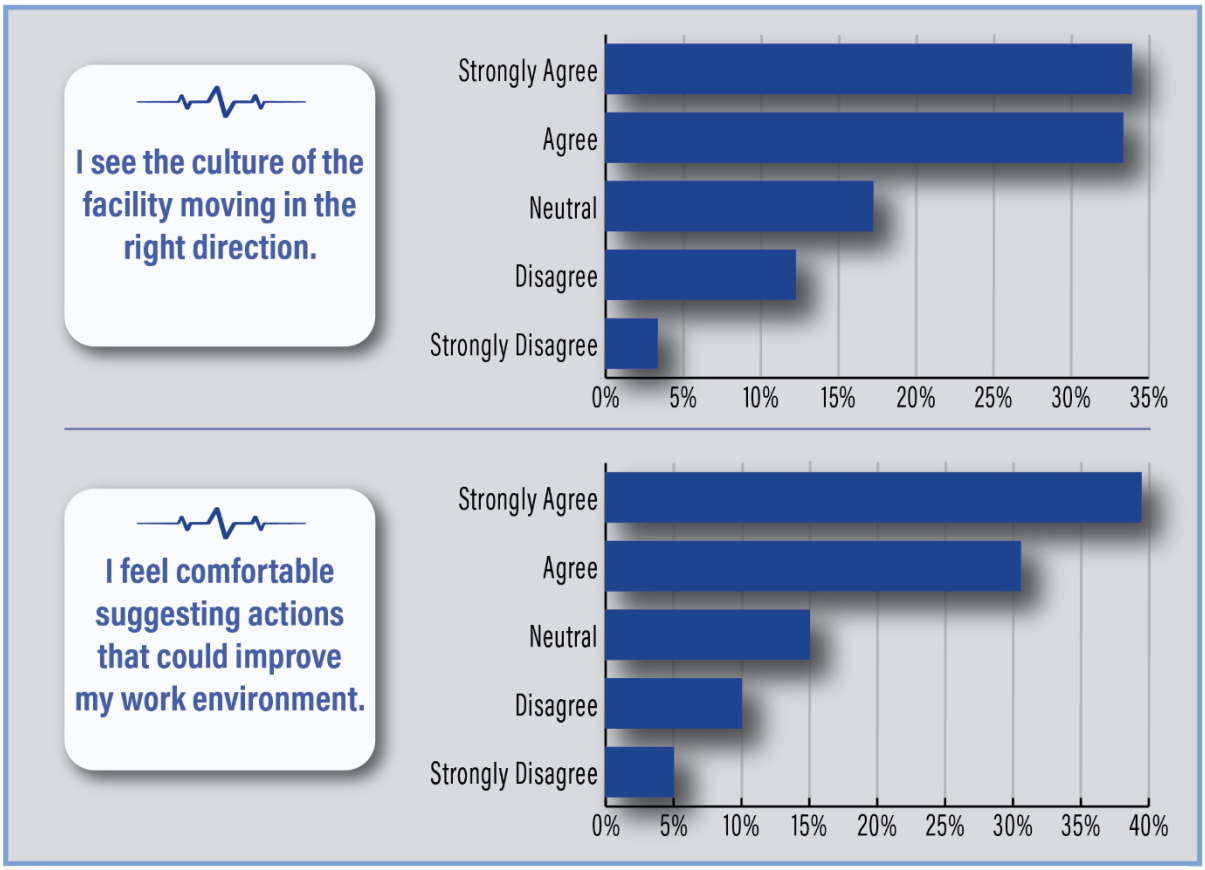


Figure 6. *Employees' perceptions of facility culture.*
Source: OIG questionnaire responses.

[27] "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.

[28] 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 All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety either increased or stayed relatively the same from FYs 2022 to 2023, and again were higher than VHA averages. Executive leaders reported employees rated the facility as a best place to work for the past few years. The leaders attributed the scores to culture and communication, pointing out that culture drives everything. They emphasized the importance of ensuring buy-in from employees and taking pride in ongoing work and the care they provide to veterans. Additionally, leaders explained they review the survey scores and comments submitted by employees and implement action plans to improve scores each year. To increase participation, they select a theme for the survey each year; this year's theme was the Olympics.

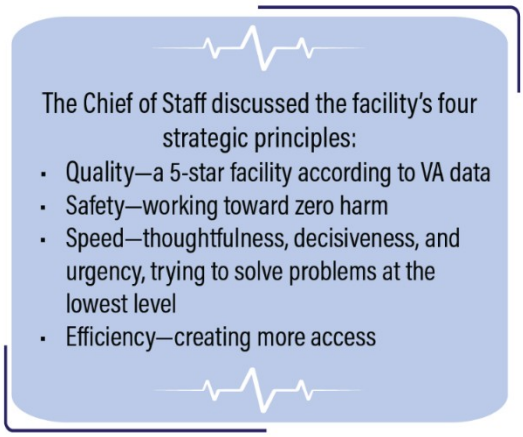


Figure 7. *Four strategic principles.*
Source: OIG analysis of interviews with facility leaders.

OIG questionnaire respondents largely indicated the VA mission, followed by pay and benefits, and job satisfaction, keep them at the facility. Respondents also indicated they feel empowered to suggest ways to improve the culture, and the culture is moving in the right direction. In an interview, leaders said they encourage employees to suggest or make changes as needed by providing them with an *Empowerment Card*, which says employees have permission to act if not a violation of any law or ethical rules, the issue is within their scope or power to change, and they are willing to be accountable for the change.

Leaders also addressed the importance of having fun and connecting with employees. A good example the OIG noted while on-site was the weekly Team Woody Day, when employees could wear clothes with a Team Woody logo. Leaders stated both employees and veterans like Team Woody Day, which promotes a sense of unity. Leaders also described various events to boost morale and motivation held throughout the year, including an employee picnic, Christmas Open House, Trunk or Treat at Halloween, a car show, and an Easter egg hunt. Leaders added there is also an Employee Morale Motivation Group that formulates additional ideas to increase morale.

Leaders described the New Employee Academy as a week-long event that occurs during the onboarding process in which human resources employees, facility leaders, and other facility personnel share their personal VA journey, and the new employees introduce themselves. The Director also spends time with the new employees talking about VA's core values and mission. Additionally, employees spend an entire day learning about veterans and veteran-centered care, and they meet veterans and hear stories about the care they receive at the facility. Leaders added that participants consistently rated the time with the veterans the best part of the orientation. The final day of New Employee Academy is dedicated to receiving feedback from the new employees and celebrating them with cake and punch to welcome them to the team.

In the OIG questionnaire, respondents largely indicated they feel comfortable reporting a patient or staff safety concern. During an interview, leaders said they share the importance of psychological safety during New Employee Academy and encourage employees to report any concerns. Leaders further emphasized the executive team firmly upholds HRO principles, has an open-door policy, and encourages patient safety event reporting. The OIG found it evident that leaders' focus was on the culture and making the facility the best place to work among healthcare facilities.

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.

In an OIG-administered questionnaire, the patient advocates indicated facility staff work hard to honor veterans and help resolve issues as they arise. One patient advocate shared details of an occasion when a veteran asked for assistance in appealing a decision about caregiver support.[31] The patient advocate reported collaborating with service chiefs and Caregiver Support Program staff to get the decision overturned. In an interview, leaders discussed the importance of being responsive to veterans' concerns and ensuring there is a mechanism for veterans to receive feedback from executive leaders.

Leaders also stated they have a great relationship with the local VSOs and meet with them regularly to keep them informed about what is occurring at the facility. The Director reported participating in VSO-sponsored events, ceremonies, and town halls. The Director shared that, during a town hall, a veteran's spouse discussed staying in the hospital's waiting area while the veteran was hospitalized and staff providing food, blankets and pillows, and clean clothes. The veteran's spouse highlighted that the veteran received outstanding care, but it would have been nice to have a place to stay.

[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 Department of Veterans Affairs (VA) "Caregiver Support Program (CSP) offers clinical services to caregivers of eligible and covered Veterans enrolled in the VA health care system." "VA Caregiver Support Program," Department of Veterans Affairs, accessed October 18, 2024, https://www.caregiver.va.gov/.

The Director and the former Chief of Staff discussed the situation and applied for a Fisher House, which VA leaders and the Fisher House Foundation approved.[32] After completion of the Fisher House, the Director wrote to the veteran's spouse that the facility now has a place for family and friends to stay when veterans are hospitalized. Throughout the site visit, the OIG noted the facility's emphasis on caring for veterans and making decisions based on what would be best for them.

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.[33] 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 8. *Facility photo.*
Source: "Hershel 'Woody' Williams VA Medical Center," Department of Veterans Affairs, accessed October 17, 2024, https://www.va.gov/huntington-health-care/locations.

Entry Touchpoints

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

[32] A Fisher House is a no-cost place to stay for families and caregivers while the veteran receives care at a VA facility. "VHA Social Work, Fisher House Program," Department of Veterans Affairs, accessed October 18, 2024, https://www.socialwork.va.gov/fisher.asp.

[33] VHA Directive 1608(1).

[34] 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.

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.[35]

Transit and Parking

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

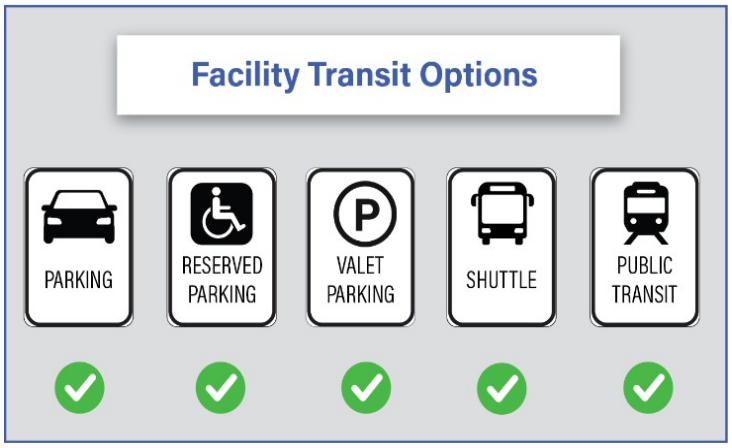


Figure 9. *Transit options for arriving at the facility. Source: OIG analysis of documents and interviews.*

The OIG easily located the facility using its public website to obtain travel information. On entering the facility, the OIG found signs that clearly directed them to parking lots, where ample parking, including accessible spaces for those with mobility issues, was available. However, the OIG reviewed a patient advocate report that included concerns about accessible parking. In an interview, Environment of Care staff acknowledged the concerns and stated a new employee parking lot had opened in the summer. The new lot alleviated some parking issues for veterans as it freed up spaces closer to the buildings.

The OIG also noted the facility offered valet parking and shuttle services and had a public bus stop outside the main entrance. The Chief of Police informed the OIG that facility staff monitor 239 indoor and outdoor cameras throughout the facility 24 hours a day, seven days a week, and VA Police patrol the site.

[35] 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 10. *Photo of the Battlefield Cross in the facility chapel.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine whether veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[36]

Using well-marked signage in the driveway and on the building, the OIG easily navigated to the canopy-covered main entrance. The entrance had power-assisted doors; was dimly lit; and contained a volunteer-run information desk, a café, and a small emergency department triage area. The OIG also noted assistive devices, such as wheelchairs, located just beyond the doors. However, several wheelchairs had torn armrests, which could prevent proper disinfection, or mechanical issues that made them unusable. To ensure patient safety, the Director should consider repairing or replacing the damaged wheelchairs.

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]

Although no facility maps were readily available upon entering the facility, the OIG found that volunteers at the information desk, as well as the Patient Advocate stationed adjacent to the desk, were eager to direct or escort patients to their appointment destinations. During an interview, the Associate Director stated staff removed many paper items during the pandemic and may have overlooked replacing the paper maps; staff addressed the issue immediately. Even without maps, the OIG was easily able to use directional signs and maps posted on the walls to navigate throughout the facility.

[36] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[38] According to an OIG-administered questionnaire, staff and volunteers received training on how to assist veterans with sensory impairments. However, the volunteers and the patient advocates were unaware the facility contracted with an American Sign Language interpreter service. The OIG requests the Director train staff and volunteers on how to access the contracted American Sign Language service.

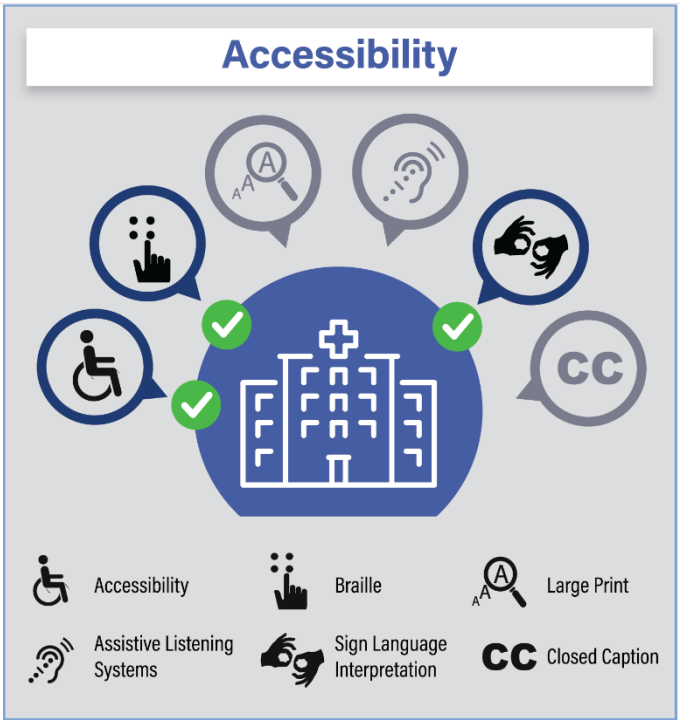


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations and questionnaire.

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] In response to an OIG questionnaire, a navigator indicated the facility has three toxic exposure navigators. As of September 9, 2024, facility staff had completed 19,459 initial toxic exposure screenings and 9,736 secondary screenings (conducted when a veteran reports a toxic exposure during the initial screening). Although one navigator reported having inadequate resources, the OIG found staff screened most veterans during primary care appointments, and the facility did not have any unresolved or overdue 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 facility met VHA's performance target for staff closing environment of care deficiencies or creating an action plan to address them within 14 days for two of three quarters in FY 2024. In the third quarter, the facility attained 89.4 percent compliance, just under the 90 percent target. The facility also met targets for senior leaders attending environment of care inspections for the first three quarters of FY 2024. The OIG did not identify any repeat findings.

General Inspection

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

The OIG inspected several clinical areas and found clear exit paths, medical equipment with current inspection stickers, locked supply rooms, and medications securely stored with separate locations for any that were expired or returned. However, the OIG also found deficiencies in several areas and noted staff did not address many of them during the site visit. The deficiencies included unsecured protected patient information in the hallways and nurses' stations on multiple units, food in storage areas that was expired or missing dates, and dirty and cracked floors.

The Environment of Care Committee chairperson stated the Environmental Management Service had vacancies, which resulted in insufficient staff to manage larger projects, like waxing floors to improve their appearance. According to the chairperson, leaders were deciding how to address these vacancies, either through hiring staff or contracting with an external service. The OIG recommends the Director ensures leaders provide a safe and clean environment of care for veterans, including having adequate staff to clean floors, protecting patient information, and ensuring foods are dated and have not expired.

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

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined the facility had processes to identify a designee to communicate test results when an ordering provider was unavailable or had left the facility. Additionally, the Chief of Staff and quality management staff stated they review and discuss External Peer Review Program communication of test results data quarterly.[43] Data showed 70 percent compliance for communicating test results as required by VHA, and 80 percent compliance for communicating test results within 30 days. They added that facility leaders developed a tracking tool to identify whether staff took action on behalf of the patient regarding their test results.

The Chief of Staff and quality management staff also discussed challenges in providers communicating test results to patients. Providers may wait to disclose test results until the patient's next appointment, if the appointment is within a few days; however, because the appointment may be canceled or rescheduled, it could delay when the patient receives the results. In addition, the high volume of alerts received by a provider in the electronic health record may delay test result communication to patients.[44] Staff said clinical application coordinators work

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

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

[43] VHA 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).

[44] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

directly with providers on how best to manage alerts. In addition, the Chief of Informatics reviews alert data weekly and notifies leaders, as well as the Medical Records Committee, if a provider's unanswered alerts exceed a set limit, so they can take action.

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 HRO.[45] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether action plans were implemented, effective, and sustained.

The OIG reviewed reports and surveys involving the facility for the past three years and did not find any open recommendations, which the Chief of Staff and quality management staff confirmed during an interview. The Chief of Staff and quality management staff explained the process for tracking action items and monitoring changes to ensure sustained improvements; According to the processes described, staff review reports from previous surveys and inspections to identify any repeated issues, and then report on any repeated issues and action plans to address recommendations at council meetings, such as the Medical Staff Council; Quality, Safety and Value Council; and Organizational Health Council. The OIG did not identify any barriers to long-term improvements related to general patient safety.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[46] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[47] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Chief of Staff and quality management staff explained the facility used an internal reporting tool to identify patient safety events and opportunities for improvements. They further stated the

[45] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.
[46] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[47] VHA Directive 1050.01(1).

Patient Safety Manager shares events with service leaders and completes root cause analyses as indicated.[48] The Chief of Staff and quality management staff identified several process improvements, including staff's development of a tool used by the cancer care coordinators to track patients' care, starting when a provider orders a test through when staff communicate the test result to the patient and take any follow-up actions. Other process improvements include staff using a folder containing care in the community results, which they scan nightly into patients' electronic health records, and using a telehealth test result reporting application.[49]

The Patient Safety Manager highlighted sharing information with clinical and nonclinical staff about patient safety and process improvements during meetings and safety forums, demonstrating collaboration occurs at all levels throughout the facility. The Patient Safety Manager reported overdue action items for improvements to the Quality, Safety, and Value Council and discussed them with executive leaders. The Chief of Staff and quality management staff said they have no barriers for improvements and facility leaders support them.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[50] 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.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

---

[48] A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

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

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

[51] 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).

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

At the time of the OIG site visit, facility leaders reported vacancies for one provider and two administrative associates in primary care. Leaders recently hired two providers, expected to start in September and October 2024, and were interviewing candidates for the third provider vacancy. Clinical staff or clinical resource hub providers were covering the vacant position. They were also currently interviewing candidates for the administrative associate positions. Leaders stated that vacancies had increased appointment wait times, but the new providers would help decrease them.

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.[53] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[54]

Through interviews, the OIG learned that panel sizes averaged between 1,000 to 1,100 patients per provider. Staff explained that many patients could benefit from more specialty care, but due to their rural location and long wait times for care in the community, most are managed in the primary care setting. Both leaders and staff reported managing complex patients in primary care increases workload because they often need multiple appointments. Additionally, many patients are on medications that require staff to frequently reassess them. As a result, fewer appointment slots are available, which delays access for new patients.

In response, leaders reported using nursing and pharmacy clinic visits to assist in managing complex patients, which frees up time for providers to see new patients. Leaders also said they use all available resources, such as home telehealth, home-based primary care, and for some patients, referrals to specialty care and care in the community.[55]

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[56] 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.

[53] "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).

[54] VHA Directive 1406(1).

[55] Home-based primary care teams "provide care that is longitudinal and comprehensive to Veterans with serious medical, social, and behavioral conditions for whom routine clinic-based care is not effective." VHA Directive 1411, *Home-Based Primary Care Special Population Patient Aligned Care Team Program*, December 28, 2023.

[56] VHA Handbook 1101.10(2).

In interviews, leaders and primary care staff stated the biggest issue affecting workflow efficiency is the burden of alerts in the electronic health record system. Staff said they receive a significant number of unnecessary alerts daily, such as updates on consults. Staff added they feel anxious about the number of alerts and fear missing something important. Leaders are aware that alert burden is a major issue and are working with VISN and national staff to decrease the number of alerts providers receive.

Staff also identified the current consult process as reducing workflow efficiency. Problems with consult management involved two inefficient practices that delay care. First, leaders discussed a recent change that resulted in nurses no longer being able to prepare parts of a consult for the provider because it was outside their scope of practice. This change increased workloads for providers, who must now enter all consult information. The second issue is the process for staff requesting results or notes from a care in the community provider and scanning them into the patients' electronic health records, which delay providers' receipt of the documents.

Facility leaders agreed the consult process of scanning documents from care in the community providers and notifying facility providers of the documents is inefficient and creates opportunities for errors. To help improve the process, care in the community leaders hired staff and purchased additional scanners to expedite uploading documents into the electronic health records, allowing providers to notify patients of results timely. Additionally, leaders determined that results needing action were not prioritized in a way providers could easily identify and address timely. Facility leaders began working with VISN staff to implement standard operating procedures to manage results that need action received from community providers. As a result of these changes, facility leaders said at the time of the site visit, there was no delay in staff scanning documents into the records and notifying providers of the results.

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 an overall decrease in veteran enrollment. Primary care staff told the OIG the addition of toxic exposure screenings did not affect team functioning because facility leaders had engaged other facility staff to help with screenings. Leaders said they hold face-to-face outreach events monthly to attract new veterans to the facility, and some veterans expressed interest in receiving care at the facility after screening positive for toxic exposures.

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.[57]

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).[58] 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."[59] The OIG determined the facility's program did not meet the HCHV5 target in FYs 2022 or 2023. In an interview, program staff reported barriers including veterans' ongoing self-isolation due to the COVID-19 pandemic, a lack of cellphone service in rural areas that hindered communication with veterans, and a flood in eastern Kentucky. The Homeless Program Coordinator stated they are currently meeting the target for FY 2024, explaining that the reinstatement of in-person outreach events and increased numbers of veterans seeking assistance at the Community Resource and Referral Center contributed to the improvement.[60]

Program staff said the point-in-time count occurred at the end of January and included counts for sheltered and unsheltered individuals. Staff explained they thought the count accurately captured the number of sheltered homeless individuals, but the count of unsheltered veterans may be less accurate due to veterans seeking places to stay during the winter. To help enroll veterans in VA care, program staff attend community meetings, review lists of homeless veterans, and help veterans apply for health benefits. In addition, staff provided a list of community partners that

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

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

[59] 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.

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

refer veterans to the program, including churches, domestic violence shelters, hair salons, hospitals, and health departments.

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).[61] Program staff stated that neither measure was applicable to the facility because they did not have contracted residential services or low-demand safe haven programs.[62] Instead, staff explained they refer homeless veterans to shelters in Huntington, Charleston, and Cashmere, West Virginia. Additionally, staff refer homeless veterans in need of nursing care to the West Virginia Veterans Home, where they can stay for 60 days while working to secure permanent housing.

To further assist veterans, HCHV staff assess their housing needs, refer them to mental health or primary care as needed, and provide case management for those eligible for health care. Staff also created a tracking sheet to monitor veterans' status after referrals for care or to the Housing and Urban Development–Veterans Affairs Supportive Housing program for assistance in securing permanent housing.

[61] 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*.

[62] HCHV Contracted Residential Services "programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022. HCHV1 and HCHV2 metrics include veterans who are discharged from contracted residential services (community-based agencies that contract with local VA facilities to provide short-term residential treatment) and low-demand safe haven programs (staffed transitional residencies for those chronically homeless with mental illness) to permanent housing.

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 facility did not meet the target for FY 2023. The program specialists explained the measure included only veterans who were eligible for VA health care, so it failed to account for all the veterans who were referred to the program for civil legal services not provided by the program. The specialists stated they assess all veterans referred to the program and connect those who are ineligible for health care to other needed services, like the Veterans Benefit Administration, HCHV program, and a vet center.[66]

In February 2021, Veterans Justice Program specialists developed a process to assist veterans with reinstating their driver's licenses in West Virginia. Previously, the state required people to attend a community driving under the influence program to reinstate licenses. The cost of the community program, as well as having to attend in person, were barriers for some veterans. Through collaboration with the West Virginia Division of Motor Vehicles, facility leaders and staff, and the VA Office of Regional Counsel, the specialists developed a program that allows veterans to complete the required 18-hour evidence-based treatment with VA providers, virtually and at no cost to the veteran.

From March 2021 through September 2023, the specialists referred 115 veterans to the program, 66 successfully completed it, and 43 regained their licenses. Based on veteran feedback, the specialists set up an online aftercare group to provide ongoing support. Additionally, they expanded the program to all VA facilities in the state, and program information and a point of contact appear on the West Virginia Division of Motor Vehicles website.

Figure 13. *Drivers Licenses Restoration Program.*
Source: OIG interview.

The program coordinator provided documentation on outreach efforts conducted by the specialists, which include community homeless events, conference sessions, and presentations to law enforcement. These outreach efforts often result in referrals from community partners, such as probation and parole officers, court staff and judges, and jail personnel; these referrals are important to the program's success.

[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] "Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling to eligible Veterans…and their families." "Vet Centers (Readjustment Counseling)," Department of Veterans Affairs, accessed January 6, 2025, https://www.vetcenter.va.gov.

Between October 2023 and September 2024, the specialists reported receiving 143 referrals, but not all veterans qualified for or agreed to services. The specialists track all referrals on an internal tool and noted reasons for not enrolling veterans, such as refusals, ineligibility for health care, or residence in another service area (these veterans receive referrals to another facility) to monitor their workload.

Meeting Veteran Needs

In response to an OIG questionnaire, the program coordinator indicated the specialists assist veterans in signing release of information documents to enable communication between community partners and jail and court staff; specialists also attend facility treatment team meetings to discuss program enrollees receiving care.

The specialists reported strong collaboration with facility mental health and primary care staff, allowing them to quickly schedule veterans for intake assessments and medical appointments. Additionally, the facility's residential rehabilitation program has helped break down barriers by admitting program enrollees into treatment.

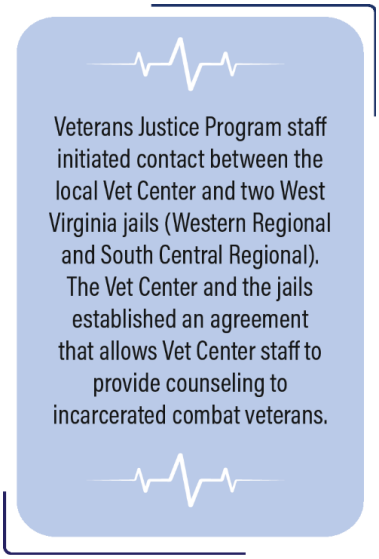


Figure 14. *An innovative practice.*
Source: OIG interview.

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

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

to the facility that are being used by veterans or their families (performance measure HMLS3).[69] The OIG determined the program met the target for FYs 2022 and 2023, and at the time of the inspection, were projected to meet the target for FY 2024.

In an interview, the coordinator reported the program had 240 housing vouchers through seven public housing agencies across 24 counties. Program staff consist of three teams, each assigned coverage of geographic regions within the service area: eastern Kentucky, Huntington, and Charleston. Although the program consistently met the target, program staff identified two barriers to meeting veterans' needs, lack of affordable housing and transportation. The coordinator and specialists stated that affordable housing is limited, and many veterans live in rural communities a good distance from the facility. Public bus service is limited to larger areas and buses do not stop at the Charleston clinic. In response, homeless program staff spend time transporting veterans to medical and housing appointments.

Program staff said they identify veterans at the Community Resource and Referral Center and through the point-in time count, homeless outreach events, churches, and nongovernmental veterans' organizations. According to facility documents, outreach staff screen homeless veterans for their housing needs and then refer them to the program to obtain assistance with permanent housing.

The Homeless Program Coordinator described a pilot program to provide a pathway to home ownership for homeless veterans. The pilot, which began in 2021, involved collaboration among the facility Housing and Urban Development–Veterans Affairs Supportive Housing program and Habitat for Humanity. Program staff worked with the local public housing authority and Habitat for Humanity to create a process allowing veterans to retain their voucher subsidy, which is redirected toward their mortgage, while continuing to receive facility case management services.

Figure 15. *Innovative Housing Practice.*
Source: OIG interview.

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 OIG determined the program met the target for FYs 2022 and 2023, and at the time of the inspection, was meeting the target for FY 2024. In the interview, program staff highlighted the work of the program's two employment coordinators as a contributing factor. The coordinators help veterans write resumes, create email accounts, search for jobs online in the facility's

[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*.

computer lab, and obtain professional clothing for interviews. Additionally, the coordinators network with employers and meet weekly with the facility's work therapy program staff.[71]

Program staff also described working with community partners. For example, churches offer weekly food pantries and monthly haircuts, while community programs supply housewares and beds, assist with rent and electric bills, and help veterans obtain personal documents (Social Security cards, birth certificates, and photo identification cards).

Program staff also highlighted their partnerships with Medical Foster Home programs.[72] When staff identify veterans who meet criteria for both programs, they refer them to the Medical Foster Home program and provide case management services throughout the admission and housing process. The staff described initial challenges with the partnership because the potential foster families were unfamiliar with being a landlord and working with the public housing authorities. Staff attended training on implementing the program, and then educated potential foster families on the benefits of being a landlord and public housing agencies about veteran benefits. At the time of the interview, one veteran was permanently housed in a medical foster home using a program voucher.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided a recommendation on a systemic issue 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.

[71] Compensated Work Therapy "provides Veterans with assistance and coaching to find and retain jobs as they continue treatment, empowering their transition to independent living." "VA Mental Health Residential Rehabilitation Treatment," Department of Veterans Affairs, accessed August 21, 2024, https://www.mentalhealth.va.gov/va-residential-rehabilitation.

[72] A Medical Foster Home provides supportive care in a private family "home-like environment to adults who are frail or physically disabled." Hershel "Woody" Williams VA Medical Center, "Housing and Urban Development-VA Supportive Housing (HUD-VASH) and Medical Foster Home Program Guidelines for Special Housing Types" (standard operating procedure), April 1, 2024.

OIG Recommendations and VA Response

Finding: The OIG found unsecured protected patient information; food that was expired or missing dates; and dirty, cracked floors in various locations due to staffing vacancies.

Recommendation 1

The OIG recommends the facility Director ensures leaders provide a safe and clean environment of care for veterans, including having adequate staff to clean floors, protecting patient information, and ensuring food is dated and has not expired.

_X_ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The Hershel “Woody” Williams VAMC Senior Leadership Team has a process in place to address the opportunity for improvement identified by the OIG HFI team. Environment of Care (EOC) rounds are conducted at all locations within the Medical Center twice a year. The EOC rounds are conducted by a multidisciplinary team and findings are shared with appropriate staff for follow up. To ensure these processes are effective, and that corrective action is occurring timely, the Chief, Quality Management and the Risk Manager, will complete a review of the documentation from the rounding team and will conduct an audit to verify that follow up has occurred.

1. Numerator = Findings from one (1) EOC rounding each week will be reviewed; the numerator will equal the number of deficiencies that have been corrected (action to be completed within 14 days for routine items; shorter time frame may occur based on the deficiency to be corrected).
2. Denominator = Findings from one (1) EOC rounding each week will be reviewed; the denominator will equal the total number of deficiencies that were recorded.
3. Compliance for closure = 90% or greater compliance with correction of identified deficiencies on a monthly basis for six (6) consecutive months.
    a. Rounding in any clinical area (where patient care is occurring or food preparation or storage is occurring) will include review of food storage, examining food products for the presence or absence of food expiration dates.
    b. Rounding in all areas will include observation for the presence or absence of unsecured, or unprotected, patient information.

4. Documentation of the audits performed by the Chief, Quality Management and the Risk Manager will be maintained on an Excel spreadsheet. An aggregate report of the audit findings will be reported monthly, beginning in July 2025, to the Executive Leadership Board until such time as compliance has been sustained at 90% for six (6) consecutive months.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to 12 VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility September 9 through 12, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[2] The OIG received a response from one VSO (Vietnam Veterans of America).

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

[4] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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: May 28, 2025

From: Director, VA Capitol Health Care Network (10N05)

Subj: Healthcare Facility Inspection of Hershel “Woody” Williams VA Medical Center in Huntington, West Virginia

To: Director, Office of Healthcare Inspections (54HF02)

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General’s (OIG’s) draft report entitled – Healthcare Facility Inspection of Hershel “Woody” Williams VA Medical Center Huntington, West Virginia.
2. I have reviewed the attached comments provided by the Medical Center Director, Hershel “Woody” Williams VA Medical Center, and concur with the submitted corrective actions. Recommendations #1 will remain open and in progress.
3. Should you require any additional information please contact the VISN 5 network office.

(Original signed by:)

Joseph Scotchlas
Deputy Network Director
For
Robert M. Walton, FACHE
Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 15, 2025

From: Director, Hershel “Woody” Williams VA Medical Center

Subj: Healthcare Facility Inspection of the Hershel “Woody” Williams VA Medical Center in Huntington, West Virginia

To: Director, VA Capitol Health Care Network (10N05)

1. I wish to extend my thanks to the Office of the Inspector General (OIG) and the Healthcare Facility Inspection team for the complete and professional review of the organization.
2. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Hershel “Woody” Williams VA Medical Center, in Huntington, West Virginia.
3. I have reviewed the report and concur with the recommendation. Attached is the facility response to the one (1) recommendation, including actions that have been completed, or are in progress, to correct the identified opportunities for improvement.
4. If you have any questions or require further information, please contact the Chief of Quality Management.

(Original signed by:)

J. Brian Nimmo, MS, FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joanne Wasko, MSW, LCSW, Director Miquita Hill-McCree, MSN, RN Tenesha Johnson-Bradshaw, MS, FNP-C Sheeba Keneth, MSN/CNL, RN Tishanna McCutchen, DNP, RN Chastity Osborn, DNP, RN Georgene Rea, MSW, LCSW
Other Contributors	Kevin Arnhold, FACHE Bruce Barnes Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Rose Griggs, MSW, LCSW LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Barbara Miller, BSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS David Vibe, MBA Dan Zhang, MSc

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 5: VA Capitol Health Care Network
Director, Hershel "Woody" Williams VA Medical Center (581)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  Kentucky: Mitch McConnell, Rand Paul
  Ohio: Jon Husted, Bernie Moreno
  West Virginia: Shelley Moore Capito, Jim Justice
US House of Representatives
  Kentucky: Thomas Massie, Hal Rogers
  Ohio: Dave Taylor
  West Virginia: Carol Miller, Riley M. Moore

OIG reports are available at www.vaoig.gov.

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.