US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Cincinnati Healthcare System in Ohio

Healthcare Facility Inspection	24-00605-182	August 6, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Cincinnati Healthcare System (facility) from July 16 through 18, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Facility staff identified leadership turnover as a system shock, and executive leaders explained that in the past couple years, the facility had lost two engineering chiefs to other government positions, and the assistant chief retired. Leaders filled the chief of engineering position with an employee who has worked at the facility for over 10 years. They are also recruiting for an assistant chief.

Prior to the site visit, some nurses assigned to the float pool expressed patient safety concerns related to changes in work assignments.[2] The OIG also discovered a National Nurses United press release related to the same issue.[3] During interviews, executive leaders explained they reassigned some nursing staff to other clinical areas, based on their clinical knowledge and

[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] Executive leaders explained that float pool staff include providers and nurses who provide temporary coverage to different clinical areas as needed.

[3] National Nurses United, "Cincinnati VA Nurses to Hold an Informational Picket for Patient Safety and to Protest Dangerous Staffing Plans," news release, April 19, 2024, https://www.nationalnursesunited.org/press/cincinnati-va-nurses-to-hold-informational-picket-for-patient-safety.

seniority, to meet the needs of the organization. Additionally, leaders said the reassigned nurses received training specific to their new work area. When specifically asked, leaders denied any patient safety concerns related to the reassignments.

The Director reported meeting regularly with veterans service organizations to understand and address veterans' concerns, such as the care coordination process, scheduling appointments, and employees' responsiveness to their needs.[4] Leaders also described partnering with a local news station to host telethons related to toxic exposure screening and suicide prevention, where a facility subject matter expert participated in an interview and other staff took calls, answered questions, and encouraged veterans to get screenings at the facility.

Environment of Care

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

The OIG found the facility had repeat findings in two areas. The facility did not meet the minimum target of 90 percent compliance for addressing environment of care deficiencies or developing an action plan to address them within 14 business days; the Veterans Integrated Service Network identified the same problem in June 2024.[5] Facility staff also failed to conduct fire drills as required, as noted in previous Joint Commission and Ascellon long term care survey reports.[6]

During the physical inspection, the OIG identified deficiencies in preventive maintenance for medical equipment throughout the facility. The OIG noted a lack of overall cleanliness in the Emergency Department, such as dirty floors and worn privacy curtains. Additionally, there were wheelchairs and other medical equipment throughout the Emergency Department hallways

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

[5] Acting Assistant Under Secretary for Health for Support, "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024. 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/.

[6] The Joint Commission, *Standards Manual*, E-dition, EC 02.03.03, July 1, 2024. Ascellon conducts regulatory and compliance surveys for government agencies which includes Long Term Care settings such as the Community Living Center. "Facility Survey and Certification Services," Ascellon, accessed April 30, 2025, https://ascellon.com/healthcare.

obstructing the exit path. Facility staff installed new disposable privacy curtains in November 2024. The OIG made several recommendations related to 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. VHA required facilities to develop a local policy and service-level workflows (which describe staff roles in the communication process) for communicating test results to ordering providers and patients by July 11, 2024.[7] At the time of the OIG inspection, clinical leaders were updating the facility's policy. In November 2024, staff submitted the updated policy to the OIG but did not provide evidence that all services had required workflows. The OIG made a recommendation.

According to VHA, staff must monitor the effectiveness of the patient test result notification process, including External Peer Review Program data.[8] Staff did not provide evidence they monitored providers' compliance with communicating urgent, noncritical test results to patients, addressed deficiencies from the External Peer Review Program, or consistently reported the external peer review data to an oversight committee. The OIG made a recommendation to address these concerns.

The OIG also identified reoccurring challenges with staff implementing timely improvement actions and patient safety managers monitoring them for effectiveness. The OIG's May 2021 comprehensive healthcare inspection report and the April 2024 Veterans Integrated Service Network Quality Management review identified similar issues.[9] During an interview, patient safety managers provided the OIG with a list of 92 open corrective actions from completed root cause analyses, with the oldest from 2017.[10] Patient safety managers explained they do not have a process to monitor root cause analysis actions or report detailed information about them to an oversight committee. Additionally, the meeting minutes did not indicate leaders were addressing open root cause analysis actions. The OIG made a related recommendation.

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

[8] VHA Directive 1088(1). The external review is a system process that supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. VHA Office of Informatics and Analytics, *External Peer Review Program (EPRP)*, March 15, 2022.

[9] VA OIG, *Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio*, Report No. 20-01276-131, May 19, 2021.

[10] A root cause analysis is an "event review that focuses on systems and processes to reduce the risk of harm. In order to prevent the problem from reoccurring, the root cause or contributing factor of the problem needs to be eliminated or corrected." VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis, Version 14*, March 2024.

Finally, the Chief of Staff reported leaders also did not always receive meaningful safety and improvement project data from the patient safety managers and staffing was inadequate. Patient safety managers agreed they had insufficient staffing and acknowledged an opportunity to improve the patient safety program. The OIG made a related recommendation.

Primary Care

The OIG determined whether 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.[11]

The facility had vacancies in primary care provider, registered and licensed practical nurse, and medical support assistant positions. A clinical leader stated medical support assistants were difficult to retain because of VA's lower pay than at community facilities. Primary care leaders shared that executive leaders had approved recruitment and retention incentives and hired a dedicated physician recruiter to expedite the time to hire and onboard providers. The leaders also said they assign float staff to cover vacant primary care positions.

To maintain a manageable panel size (the number of patients assigned to a primary care team), the leaders said they moved the Dearborn clinic to a larger space. The move allowed them to add a new primary care team to that location, accommodate new patients, and balance panel sizes.

The OIG also noted a decrease in veteran enrollment between fiscal years 2021 and 2023. The Associate Chief of Staff, Primary Care attributed it partly to the patient deactivation process. The leader explained that VHA automatically removes veterans from their primary care providers' panel if they have not been seen in more than three years. Veterans are placed on a deactivation list 120 days before the removal, and staff who previously managed the list had not contacted them to schedule an appointment prior to the deadline. The chief highlighted there were 300 veterans on the list, and primary care staff began contacting them in June 2023 and had scheduled 131 appointments within 30 days.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. Program staff made strong efforts to engage with unsheltered veterans and had close working relationships with community partners, enabling them to quickly help meet veterans' needs. Despite the loss of housing options within voucher limits when landlords increased rental costs,

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

program staff, with the help of community partners, successfully engaged landlords to keep veterans housed. Program staff also used technology and information resources effectively, and collaborated with community law enforcement and justice systems to meet the needs of enrolled veterans.

What the OIG Recommended

The OIG made nine recommendations for improvement.

1. The Director ensures staff correct deficiencies found during comprehensive environment of care rounds or develop an action plan to address them within 14 business days.
2. The Director ensures staff conduct fire drills once per shift, per quarter, in each patient area.
3. Executive leaders ensure staff inspect all medical equipment timely, and equipment has preventive maintenance labels.
4. Executive leaders ensure staff properly clean patient care areas in the Emergency Department.
5. Executive leaders ensure staff keep exit pathways free from obstructions.
6. The Director ensures staff develop service-level workflows for the communication of test results.
7. The Director ensures staff implement a facility-wide process to monitor providers' communication of urgent, noncritical test results to patients, and report compliance to an appropriate oversight committee.
8. Executive leaders ensure staff implement actions from root cause analyses timely, monitor actions for effectiveness and sustained improvement, and report compliance to an appropriate oversight council.
9. The Director evaluates the patient safety program, including staffing, to ensure executive leaders receive meaningful patient safety information and improvement project data.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and acting Medical Center Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, and the responses within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, 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
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Cincinnati Healthcare System
Cincinnati, Ohio
Level 1b-High Complexity
Hamilton County
Hospital Referral Region: Cincinnati

Description of Community

POPULATION

Female 1,184,170	Male 1,141,940
Veteran Female 13,442	Veteran Male 125,603

Homeless - State **10,654**

Homeless Veteran - State **633**

MEDIAN INCOME

$60,526

EDUCATION

89% Completed High School

56% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **89**

SUBSTANCE USE

24.2% Driving Deaths Involving Alcohol

18.4% Excessive Drinking

983 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+

4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	893,941
Carpool	86,480
Work at Home	71,419
Walk to Work	22,322
Public Transportation	15,362
Other Means	9,791

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**23 Minutes, 17 Miles**
Specialty Care	**46 Minutes, 38 Miles**
Tertiary Care	**103 Minutes, 96 Miles**

Access to Health Care

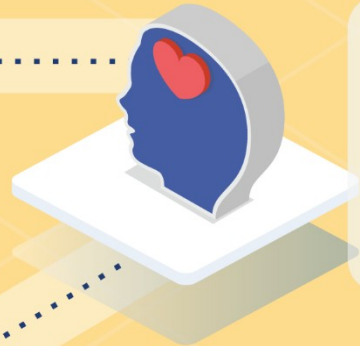
ACCESS

VA Medical Center Telehealth Patients 14,520

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	39%
<65 without Health Insurance	12%

Health of the Veteran Population

278 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

12,535

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.03 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
19	34

Health of the Facility

UNIQUE PATIENTS

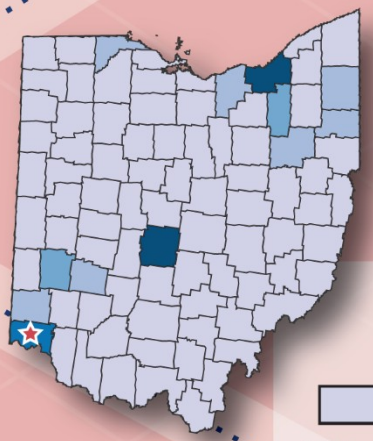
Unique Patients VA and Non-VA Care	42K
Unique Patients VA Care	40K
Unique Patients Non-VA Care	13K

COMMUNITY CARE COSTS

Unique Patient $30,346	Outpatient Visit $326
Line Item $1,001	Bed Day of Care $277

STAFF RETENTION

Onboard Employees Stay <1 Yr	13.56%
Facility Total Loss Rate	11.64%
Facility Retire Rate	2.01%
Facility Quit Rate	7.97%
Facility Termination Rate	1.54%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.11% 2.04% 3.96% 5.88% 7.80% 9.73%

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 cyclical review program to help accomplish its mission. Healthcare Facility Inspection 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."*

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

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

High Reliability Organization Framework

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

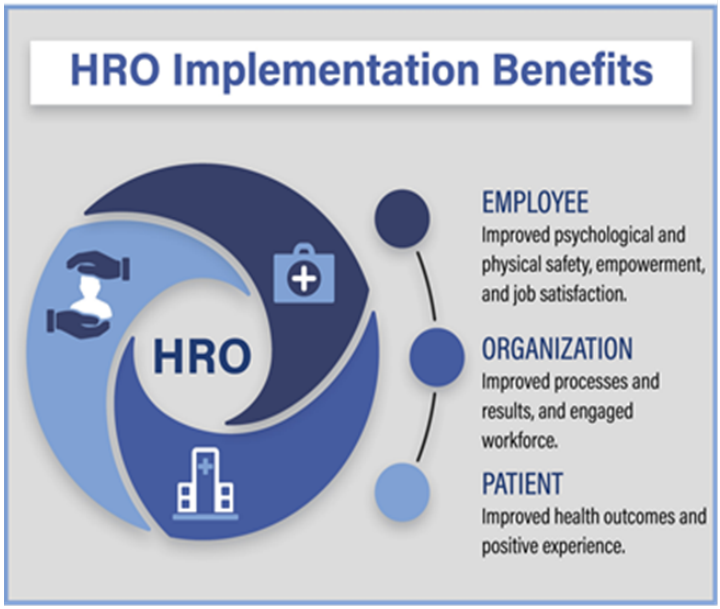


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

[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.

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 Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

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

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

The VA Cincinnati Healthcare System (facility) is a teaching and research hospital that opened in 1954 and provides healthcare services to approximately 41,000 enrolled veterans at 12 locations in Indiana, Kentucky, and Ohio. At the time of the inspection, the facility had an executive team consisting of the Executive Medical Center Director (Director), Associate Director, Chief of Staff, Associate Director of Patient Care Services, and Assistant Director (acting).

The Director served as the Associate Director of Patient Care Services for approximately two and a half years before being appointed to the current role in June 2021. The Chief of Staff had been in the position since September 2020, and the Associate Director of Patient Care Services was selected in October 2021. The Associate Director, who had been in the role since October 2019, was the most tenured. The Assistant Director was assigned to another VA facility in June 2024, and the Chief of Fiscal has served in the position since then. The facility had 116 hospital, 48 Community Living Center, and 90 Residential Rehabilitation Treatment Program beds, and in fiscal year (FY) 2023, the budget was over $778 million.[13]

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

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 10, 2024, https://www.va.gov/VA_CLC. "Residential Rehabilitation Treatment, sometimes referred to as inpatient residential or domiciliary care, provides comprehensive treatment and rehabilitation services to Veterans with mental health conditions like posttraumatic stress disorder (PTSD), depression, and substance use disorder." "Mental Health," Department of Veterans Affairs, accessed April 14, 2025, https://www.mentalhealth.va.gov/get-help/va-residential-rehabilitation/index.asp.

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

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

The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

System Shocks

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

In the OIG's facility-wide questionnaire, some respondents identified turnover in key leadership positions as a system shock.[19] The Associate Director said the engineering department had experienced several leadership changes in recent years and believed this was the turnover respondents identified in the questionnaire. Two engineering chiefs accepted other government positions, and an assistant chief retired, collectively leading to a loss of institutional knowledge. Therefore, the Associate Director reported hiring a new Chief of Engineering, who had worked at the facility in a different role for over 10 years, and actively recruiting to permanently fill the assistant chief position.

Additionally, the OIG identified a staffing change that had affected the organization. Prior to the inspection, the OIG received several emails from nursing staff about a National Nurses United press release that reported patient safety concerns over executive leaders' decision to realign float pool nurses to other clinical care areas.[20] The Director explained that to assist with nursing needs during the COVID-19 pandemic, they created a float pool with 75 full-time nurses, putting

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

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

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

[19] The OIG sent the questionnaire to 3,753 individuals, and 449 respondents completed it. Of the respondents, 181 identified leadership turnover a system shock.

[20] National Nurses United, "Cincinnati VA Nurses to Hold an Informational Picket for Patient Safety and to Protest Dangerous Staffing Plans," news release, April 19, 2024, https://www.nationalnursesunited.org/Picket-for-Patient-Safety. Executive leaders explained that float staff include providers and nurses who provide temporary coverage to different clinical areas.

the facility above its normal nurse staffing levels. The Deputy Associate Director of Patient Care Services stated that as the needs of the facility changed, executive leaders decided to reassign 27 float pool nurses to other clinical areas, with the majority going to the Community Living Center.

The OIG asked executive leaders whether they had patient safety concerns because of the reassignments, and the leaders denied having any. Executive leaders said they reassigned nurses based on seniority, but the reassignments caused those nurses' schedules and supervisors to change. Executive leaders explained they also reassigned nurses based on their experience. Leaders shared that these nurses received a two-week orientation with an experienced nurse, and training specific to the patient population to which they were assigned. Further, they had two educators assigned to the Community Living Center available to answer questions and support them as needed.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[22] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]

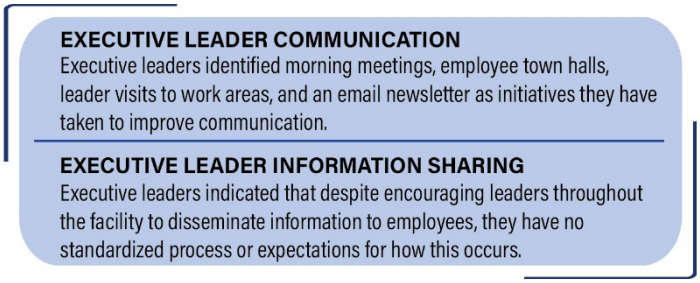


Figure 4. *Leader communication with staff.*
Source: OIG interviews with facility leaders.

Some respondents to the OIG's questionnaire had negative opinions about the usefulness, clarity, and frequency of leaders' communication. Executive leaders said they communicate information

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

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

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

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

in multiple ways, including a daily meeting with specific facility and community-based outpatient clinic staff, an electronic newsletter, and quarterly town hall meetings. The Assistant Director (acting) clarified that while there were standardized communication processes for executive leaders through structured meetings and forums, communication was less consistent at lower levels of the organization. Executive leaders should ensure staff improve communication throughout the facility.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26]

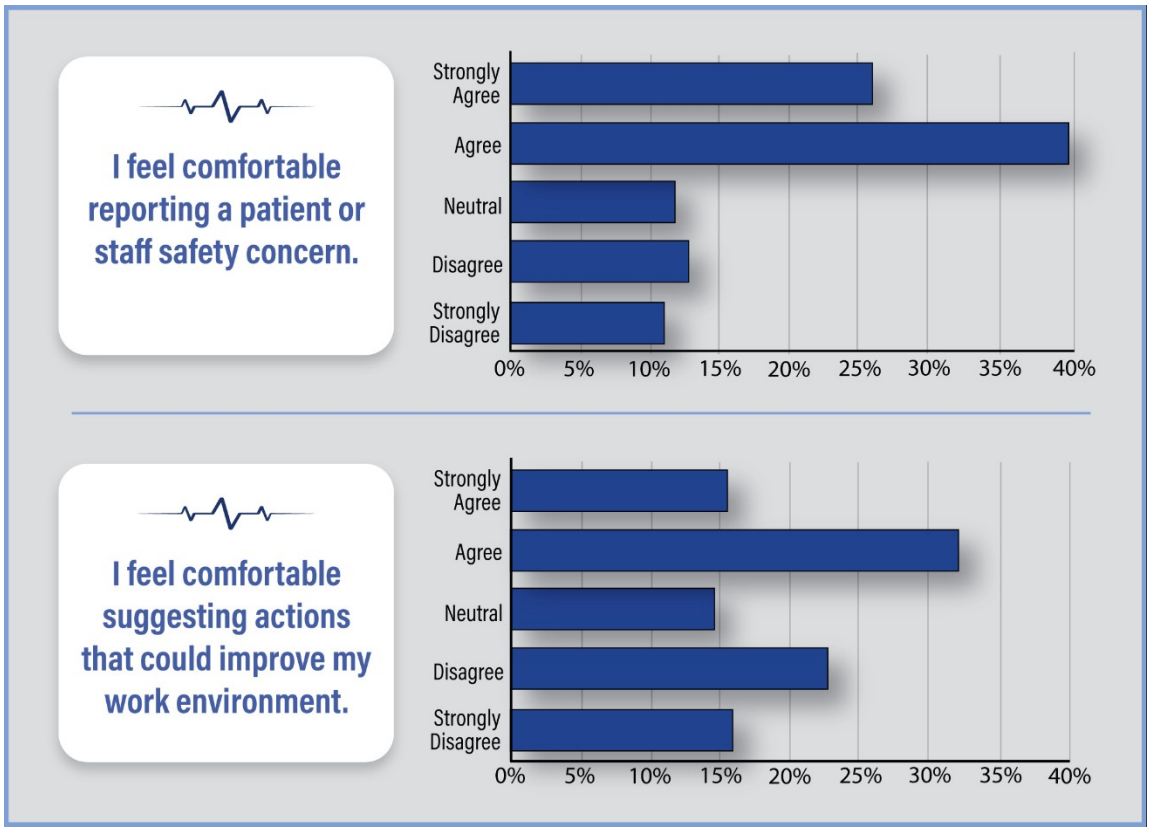


Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

[25] "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.

[26] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

The facility's All Employee Survey scores related to fear of reprisal, supervisor trust, psychological safety, and best places to work consistently improved from FYs 2021 through 2023. Additionally, OIG questionnaire respondents indicated they feel comfortable suggesting ways to improve their work environment and reporting safety concerns. The Associate Director explained that executive leaders predominantly rely on VA survey scores and feedback from town halls to gauge employees' experiences. Further, the Associate Director reported the leaders believe improvement in the survey data and the facility's high retention rate indicate positive employee experiences. The Associate Director also shared that leaders established an Employee Engagement Committee, which organizes activities like door decorating contests, employee outings, and recognition events.

Respondents to the OIG questionnaire identified stress and burnout as reasons to consider leaving the organization. However, leaders reported believing most employees leave due to retirement, promotion, or for family, while physicians often leave due to salary. When the OIG highlighted the discrepancy between respondents' and leaders' perceptions, the leaders said survey scores for stress and burnout had improved in the last year, but did not offer examples of actions they took to minimize these concerns.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[27] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[28] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Patient advocate and VSO questionnaire respondents indicated veterans could provide feedback to facility leaders. They shared that veterans had difficulty contacting their care team. To address their concern, leaders reported the patient advocates and call center leaders had been working with clinic staff to improve the process, which had shown some success. Leaders also said they review call center data every two weeks to monitor staff's responsiveness to veterans' calls.

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

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

The Associate Director reported obtaining information about veterans' experiences through multiple VA data sources, including the Patient Family Advisory Council.[29] Furthermore, the Director discussed engaging with local VSOs through scheduled and unscheduled meetings and quarterly town halls in which veterans participate, and staff provide facility updates and address questions and concerns.[30]

Additionally, the Director reported that when VHA first introduced the PACT Act, veterans wanted to know how it would affect their benefits, and they raised these concerns during town halls. In response, a VSO representative now attends the town halls to answer benefit-related questions. Facility staff also partnered with a local news station to hold telethons on the PACT Act and the Veterans Comprehensive Prevention, Access to Care, and Treatment Act.[31] During the telethon events, a local reporter interviews a facility subject matter expert, and other staff answer callers' questions, encourage veterans to get screenings at the facility, and connect veterans with local VSOs.

[29] The Associate Director explained that VA data sources include VA's Survey of Healthcare Experience of Patients, VSignals, the Patient Advocate Tracking System-Replacement, feedback to a primary care experience screening question, and rounding with the patient advocates. Veterans may receive VA's Survey of Healthcare Experience of Patients asking them about their experience after a visit to a VA facility, including "ease and speed of making an appointment, if their provider spent enough time with them and if they discussed their medications." "VA's Survey of Healthcare Experience of Patients," VA News, accessed July 23, 2024, https://news.va.gov/survey-healthcare-experience-patients. Veterans Signals, commonly referred to as VSignals, is a survey platform used by the Veterans Experience Office to measure trust in the VA. "Veteran Trust in VA," Department of Veterans Affairs, accessed August 5, 2024, https://www.va.gov/initiatives/veteran-trust-in-va. The Patient Advocate Tracking System-Replacement "is a web-based application that supports Patient Advocates and VHA staff in tracking and trending Veteran complaints in one centralized repository." Veterans Health Administration, Office of Patient Advocacy, *Veteran Centered Complaint Resolution Guidebook*, January 2023.

[30] To encourage town hall participation, the Director explained they provide approximately 18,000 to 20,000 reminder calls to veterans the night before and the day of the event and generally have approximately 2,000 to 2,300 call-in participants. When a veteran submits a question during the town hall, a call operator records it, and if there is not time to answer the call during the meeting, patient advocates follow up with the veteran within a week.

[31] Veterans Comprehensive Prevention, Access to Care, and Treatment Act (COMPACT) of 2020, Pub. L. No. 116-214, 134 Stat. 1026 (2020). Under the law, "Veterans with acute suicidal crisis can go immediately to any VA or non-VA health care facility for emergency health care at no cost to them." Department of Veterans Affairs, "COMPACT Act Expands Free Emergency Suicide Care for Veterans," news release, February 1, 2023, https://www.va.gov/poplar-bluff-health-care/news-releases.

ENVIRONMENT OF CARE

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

Figure 6. *Facility photo.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

[32] VHA Directive 1608(1).

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

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

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.

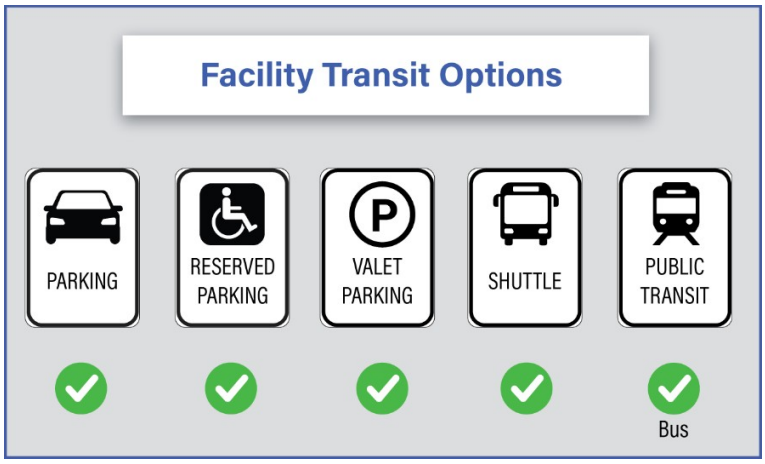


Figure 7. *Transit options for arriving at the facility.*
Source: Facility staff, documents, and OIG observations.

The OIG team located the facility using directions from its website and, on arrival, noted multiple parking lots, a multilevel parking garage, and public transit stop signs close to the main entrance. According to staff, the facility offers valet parking, and a volunteer-operated golf cart service to transport veterans from parking lots to the facility.

Main Entrance

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

The OIG found clear signs leading to the main entrance. The entrance had a covered drop-off and pickup zone, and a wheelchair center located near the valet parking area. The entrance was well-lit, clean, and equipped with an automatic door. The Chief of Engineering reported plans to move the wheelchair center closer to the main entrance and renovate the lobby to increase space and a wall showcasing all the military service branches.

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.[36]

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

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

The OIG observed Red Coat Ambassadors at the main entrance information desk assisting veterans with directions.[37] The OIG easily found specific clinical and nonclinical areas using directional signs, directories posted on walls, and the Med Maps electronic wayfinding application.[38]

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[39] The main entrance lacked specific visual and auditory features like sound absorbing panels and audio instructions, as recommended by VHA interior design guidelines and the Architectural Barriers Act.[40]

Although the OIG noted small print on a directory, there was an associated map and a code that veterans could scan with their phones to access navigational information. In addition, the OIG confirmed that braille and audio instructions were available in elevators. Although the main entrance did not have sound absorbing panels, the OIG did not hear excessive noise in the area and therefore did not make a recommendation.

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: Facility staff and OIG observations.

[37] Red Coat Ambassadors are individuals who wear a red coat or vest and are stationed at the main entrance during business hours. Red Coat Ambassadors help visitors with navigation and provide easy access to facility information. "What is the Red Coat Ambassador Program?," Department of Veterans Affairs, Veterans Experience Office, accessed April 28, 20254, https://www.news.va.gov/RedCoatAmbassadorProgram.pdf.

[38] Med Maps is an interactive mobile application that provides visitors with wayfinding support. "Med Maps Interactive A to Point B Wayfinding Solutions," Med Maps, accessed April 29, 2025, https://www.medmaps.com.

[39] 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.

[40] VHA Directive 1850.05; Access Board, *Architectural Barriers Act (ABA) Standards*.

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.[41]

In response to an OIG questionnaire, one of the navigators confirmed the facility had two toxic exposure screening navigators who were both providers and can screen veterans. The Chief of Patient Business Services explained that navigators monitor the facility's screening performance and educate other providers about completing secondary screenings (conducted when a veteran reports a toxic exposure), if needed. The OIG reviewed facility data and found no backlog of secondary screenings.

During an interview, staff said veterans may walk in and request screening with a navigator or their assigned primary care provider. The OIG also learned that navigators and other staff use a mobile unit to screen veterans for toxic exposure every Wednesday from 10 a.m. to 2 p.m., as part of community outreach.

The OIG observed toxic exposure screening information at the main entrance desk. Staff said they train Red Coat Ambassadors on the screening process, but the ambassador said they were unaware of the process. The Chief of Patient Business Services said leaders plan to station a navigator near the main entrance to offer veterans toxic exposure education and screenings.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[42] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed performance data and found the facility did not meet the minimum target of 90 percent compliance for closing environment of care deficiencies or having an action plan for improvement within 14 business days in the first three quarters of FY 2024. In June 2024, a Veterans Integrated Service Network (VISN) team reviewed the facility's Safety Management

[41] 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.

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

Program and identified the same issue.[43] VHA requires facility staff to address deficiencies found during comprehensive environment of care rounds or develop an action plan to address them within 14 business days.[44] The Director must also ensure staff track the deficiencies until they are resolved.[45] When staff fail to address the deficiencies promptly, it may increase unsafe conditions for both patients and staff. The OIG recommends the Director ensures staff correct deficiencies found during comprehensive environment of care rounds or develop an action plan to address them within 14 business days.

The OIG reviewed previous survey reports and noted the July 2022 Joint Commission and December 2023 Ascellon long term care survey reports cited the facility for not conducting fire drills as required.[46] For example, staff only conducted a fire drill in the Emergency Department during the second and third shift in quarter one. After reviewing fire drill reports for the first two quarters of FY 2024, the OIG also found staff did not conduct fire drills as required. The Joint Commission requires hospital staff to conduct fire drills once per shift, per quarter, in each patient care area.[47]

Failure to conduct fire drills may result in staff being unprepared to respond in an emergency and risk patient safety. The Chief of Industrial Hygiene and Safety stated the safety specialist position (who is responsible for fire drills) had been vacant for nine months but has since been filled. The OIG recommends the Director ensures staff conduct fire drills once per shift, per quarter, in each patient area.

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 found that several pieces of medical equipment in the Community Living Center, Emergency Department, and Medical Surgical Unit had conflicting dates on preventive maintenance labels, or the date indicated the scheduled maintenance was overdue. According to

[43] 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/.

[44] Acting Assistant Under Secretary for Health for Support, "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024.

[45] VHA Directive 1608(1).

[46] Ascellon conducts regulatory and compliance surveys for government agencies which includes Long Term Care settings such as the Community Living Center. "Facility Survey and Certification Services," Ascellon, accessed April 30, 2025, https://ascellon.com/healthcare/.

[47] The Joint Commission, *Standards Manual*, E-dition, EC 02.03.03, July 1, 2024.

the Comprehensive Environment of Care Committee meeting minutes, this issue was one of the facility's top deficiencies identified during environment of care rounds for FY 2024, but there was no discussion of action plans for staff to track the deficiency until it was resolved.

The Joint Commission requires staff to inspect and maintain medical equipment.[48] During an interview, the OIG learned the vendor responsible for completing inspections applied two different labels on some equipment. The Supervisory Biomedical Engineer added that staff responsible for conducting the preventive maintenance often have challenges accessing secured storage rooms to inspect the equipment.

When staff do not inspect medical equipment, it could malfunction or produce incorrect readings, resulting in patient harm. The OIG recommends executive leaders ensure staff inspect all medical equipment timely, and equipment has preventive maintenance labels.

During the general inspection, the OIG found the Emergency Department lacked overall cleanliness throughout the area and had dirty flooring and visibly worn privacy curtains. The Joint Commission requires facility staff to reduce the risk of infection to patients and staff.[49] The Acting Chief of Environmental Management Services attributed the deficiencies to staffing shortages and further explained the facility was transitioning to disposable curtains, which were on back order. In November 2024, facility staff provided evidence to the OIG that they had installed disposable privacy curtains in the Emergency Department.

Failure to properly clean patient care areas can create a risk of infection for patients and staff. The OIG recommends executive leaders ensure staff properly clean patient care areas in the Emergency Department.

The OIG found the hallways in the Emergency Department cluttered with wheelchairs and other medical equipment that blocked the exit path. The Joint Commission requires exit pathways to remain clear and unobstructed.[50] During an interview, Comprehensive Environment of Care Committee members acknowledged not having a plan to address the deficiency.

When hallways are full of obstructions, it may interfere with staff and patients' ability to move throughout an area efficiently and safely during an emergency. The OIG recommends executive leaders ensure staff keep exit pathways free from obstructions.

[48] The Joint Commission, *Standards Manual*, EC.02.04.01, January 14, 2024.

[49] The Joint Commission, *Standards Manual*, E-dition, IC.06.01.01, July 1, 2024.

[50] The Joint Commission, *Standards Manual,* E-dition, LS.02.01.20, EP 14, July 1, 2024.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[51] 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.[52] 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.

At the time of the inspection, clinical leaders said they were updating the facility policy and service-level workflows, and the facility liaison provided the OIG with a draft copy of the policy for review. VHA required facilities to implement a policy and service-level workflows (which describe team member roles in the communication process) for communicating test results to ordering providers and patients by July 11, 2024.[53] In November 2024, staff submitted an updated policy to the OIG that aligned with the directive but did not provide evidence of service-level workflows. The OIG recommends the Director ensures staff develop service-level workflows for the communication of test results.

A quality management staff member said the External Peer Review Committee, which oversees external peer review data, had not met for several years. VHA requires staff to monitor the effectiveness of the patient notification process.[54] In addition, the facility director is responsible for ensuring staff review and address deficiencies identified in External Peer Review Program results, such as providers' timely communication of test results to patients.[55]

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

[52] 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.

[53] VHA Directive 1088(1).

[54] VHA Directive 1088(1).

[55] VHA Directive 1088(1). The External Peer Review Program is a system process that supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. VHA Office of Informatics and Analytics, *External Peer Review Program (EPRP)*, March 15, 2022.

A quality management staff member said that in June 2024, they recognized the need to restart the External Peer Review Committee to review data and discuss opportunities to improve performance. Leaders said they were also developing a facility-wide process to monitor providers' compliance with communicating test results to patients.

The lack of a process to monitor the communication of test results may negatively affect patients receiving timely care because if they are not aware of the results, they may not seek needed follow-up. Further, leaders' lack of oversight related to the communication of test result data may hinder process improvements. The OIG recommends the Director ensures staff implement a facility-wide process to monitor providers' communication of urgent, noncritical test results to patients, and report compliance to an appropriate oversight committee.

Action Plan Implementation and Sustainability

Figure 9. *Status of prior OIG recommendations. Source: OIG analysis of documents.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[56] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained. The OIG noted that all recommendations for improvement from the previous OIG comprehensive healthcare inspection in July 2020 were closed.[57]

The OIG asked the managers if they had open improvement actions from completed root cause analyses (RCAs) that staff had not implemented, and the managers provided a list of 92 actions, with the oldest from December 2017 and several from 2018. When staff use the RCA process to complete a comprehensive review of a patient safety event, VHA requires them to implement improvement actions and monitor them for effectiveness and sustained improvement.[58] It also

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

[57] VA OIG, *Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio*, Report No. 20-01276-131, May 19, 2021.

[58] An RCA is an "event review that focuses on systems and processes to reduce the risk of harm. In order to prevent the problem from reoccurring, the root cause or contributing factor of the problem needs to be eliminated or corrected." VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, Version 14, March 2024.

advises staff to document improvement actions and outcomes and update the patient safety committee or workgroup during meetings.[59]

According to the April 2024 VISN Quality Management review of the facility's Quality and Patient Safety Program, VISN leaders suggested staff create a patient safety committee. At the time of the site visit, patient safety managers acknowledged that leaders had not established a committee, but they update Quality and Patient Safety Council members, which include executive leaders, on patient safety events during monthly meetings.[60] The OIG reviewed the council's meeting minutes and verified that managers provided general updates, such as the number of closed and active RCAs.

Failing to implement actions is a repeat finding from the OIG's previous comprehensive healthcare inspection.[61] The patient safety managers said they do not have a process to monitor RCA actions or report detailed information about the actions to the Quality and Patient Safety Council. The Director also reported being aware of the open RCA improvement actions and said leaders created the Executive Leadership Council in February 2024 to improve oversight. However, the OIG found no related updates in the council's meeting minutes.

When staff do not implement and monitor RCA actions, and executive leaders do not provide adequate oversight of the patient safety program, patients may be at risk of experiencing preventable harm. The OIG recommends executive leaders ensure staff implement actions from RCAs timely, monitor actions for effectiveness and sustained improvement, and report compliance to an appropriate oversight council.

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.[62] 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.[63] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality management staff and executive leaders said they identify patient safety concerns and opportunities for continuous improvement through various activities. For example, they review events in the Joint Patient Safety Reporting system daily, discuss issues in patient safety forums

[59] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, Version 14.

[60] After the site visit, the acting Medical Center Director said the patient safety team also began reporting patient safety information at other meetings and committees, such as the patient safety forum.

[61] VA OIG, *Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio*.

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

[63] VHA Directive 1050.01(1).

and hold continuous readiness meetings, which are open to all employees, to be prepared for unannounced surveys.[64] Executive leaders said they discuss events that affect daily operations during morning report meetings, where the leaders encourage employees to participate.[65]

When the OIG asked about obstacles or barriers to process improvements, quality management staff explained they had difficulty getting buy-in from staff because they reported being overwhelmed by many proposed improvement actions. The patient safety managers shared that having two managers is not adequate staffing and there is an opportunity to improve how they manage the patient safety program.

The Chief of Staff agreed that two managers were insufficient for the program, specifically related to providing executive leaders with meaningful safety and improvement project data. The chief further explained that some quality management staff are assigned to different work areas, such as primary care and surgery, and leaders implement process improvement initiatives specific to their areas. The leaders believed quality management staff could improve their processes by grouping similar concerns across areas and implementing sustainable facility-wide actions. The OIG recommends the Director evaluates the patient safety program, including staffing, to ensure executive leaders receive meaningful patient safety information and improvement project data.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[66] 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.[67] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

[64] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

[65] Executive leaders explained they invite key staff members to the daily morning report meeting; they expect the invitees to attend, but anyone else can choose to attend as well.

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

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

staffing shortages.[68] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Primary care leaders reported the facility has seven outpatient clinics with 38 primary care teams. VHA recommends a ratio of at least 3.0 full-time equivalent support staff to each full-time equivalent primary care provider.[69] Based on data from the third quarter of FY 2023 through the second quarter of FY 2024, the OIG determined, on average, the primary care teams' staff ratio was consistent with VHA guidelines.

In response to an OIG questionnaire, a staff member identified current vacancies, including two primary care provider, two registered nurse, three licensed practical nurse, and seven medical support assistant positions, mainly among teams in Cincinnati and Dearborn. Primary care leaders said executive leaders approved recruitment and retention incentives and hired a physician recruiter to expedite the hiring and onboarding process. The leaders added that public affairs staff also expanded job marketing strategies to improve recruitment. The Associate Chief of Staff, Primary Care stated that in FY 2023, they filled 14 primary care provider positions with these recruitment efforts.

The Chief Nurse, Primary Care attributed most of the nursing vacancies to nurses pursuing advanced education through the facility's employee incentive scholarship program, and then transferring to a different position within the organization based on their new skills and knowledge. According to the Medical Support Assistant Supervisor, administrative staff often leave for higher pay at non-VA hospitals or to positions outside of primary care to pursue a better work-life balance.

Primary care leaders explained that clinic managers discuss staffing needs during their weekly meetings and daily huddles to ensure patients' access to care. The leaders said float staff cover vacant primary care positions, assist with answering telephone calls, and address notifications, such as test results, in patients' electronic health records. The leaders added that each member of the team has an assigned surrogate for planned leaves of absence. The OIG reviewed access data from the third quarter of FY 2023 through the second quarter of FY 2024 and determined that despite vacancies, new and established patients had appointment wait times of less than a week from the date they requested the appointments.

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.[70] The OIG

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

[69] VHA Handbook 1101.10(2).

[70] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[71]

The Associate Chief of Staff, Primary Care told the OIG that facility leaders' goal is to expand when a teams' panel size is at 85 percent. For example, leaders said the Dearborn clinic had panel sizes over 85 percent, so they moved the clinic to a larger building and added a new primary care team. The new team takes patients from teams with higher panel sizes and has the capacity to accept new patients. The OIG determined the facility's average primary care panel size was about 89 percent of the expected size for the first and second quarters of FY 2024.

The Associate Chief also explained that higher panel sizes negatively affect efficiency and quality of care. The Facility Principal Coordinator for primary care reported meeting weekly with primary care leaders to discuss factors affecting panel sizes, planned closures in primary care clinics, and new patients assigned to primary care teams.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[72] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

The Associate Chief of Staff, Primary Care and clinical staff described a process improvement project to reduce inefficiencies related to the number of test result notifications primary care providers receive in electronic health records. The associate chief explained that informatics staff changed the notification process so that only the ordering provider would receive notifications for normal results, instead of all providers involved in the patients' care. The associate chief added that the change led to fewer notifications for primary care providers, which allowed them to address abnormal test results more quickly.

The Facility Principal Coordinator reported that primary care staff are currently piloting a new process to improve patients' experiences when they call to make an appointment. The coordinator said that previously, operators transferred callers several times before they spoke to a primary care staff member to schedule an appointment. With the new process, patients or staff from another department can call 1 of 12 designated primary care staff. The coordinator anticipated the process would be fully implemented by September 2024.

[71] VHA Directive 1406(1).

[72] VHA Handbook 1101.10(2).

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 reviewed the facility's veteran enrollment data and noted a decrease between FYs 2021 and 2023. The Associate Chief of Staff, Primary Care identified factors that may have contributed to the decreased enrollment: low population growth and challenges with the patient deactivation process.[73]

The associate chief explained that staff responsible for managing the deactivation list did not proactively contact patients to schedule a visit before the system automatically removed them from the provider's panel. To address this problem, primary care staff assumed responsibility for the process in June 2023 and scheduled primary care appointments for 131 of the 300 listed patients within 30 days to avoid automatic deactivation.

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 and case management, and if needed, refer veterans to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[74]

[73] The Associate Chief of Staff, Primary Care explained that patients are automatically removed from the panel after three years of not being seen by their primary care providers. Veterans nearing three years are placed on a deactivation list 120 days before the removal date.

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

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).[75] 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."[76]

The HCHV Program Coordinator reported that the VHA Homeless Program Office did not require staff to monitor HCHV5 performance in FY 2023 due to the low number of unsheltered veterans in the coverage area. However, the OIG noted that although the facility did not meet the year-end performance target of 100 percent in FYs 2021 and 2022, program staff made strong efforts to engage with unsheltered veterans, and the program's performance reached 82 and 86 percent, respectively.

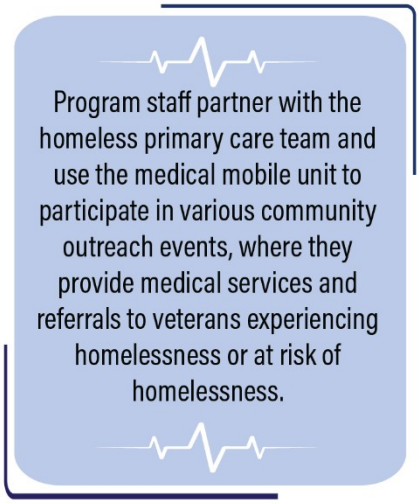

Figure 10. *Veteran engagement. Source: OIG interview.*

Program staff discussed collaborating with community partners to conduct a yearly Stand Down outreach event, where veterans can receive clothing, food, healthcare services, and information on job opportunities.[77] The staff also reported conducting outreach in streets, homeless shelters, and hotels, where they identified veterans and connected them with appropriate resources. The staff further described operating a walk-in clinic Monday through Friday from 8:00 a.m. to 4:30 p.m., where they assess unsheltered veterans and refer them to services, such as transitional housing. Staff also reported positive relationships with community partners, who refer homeless veterans, or those at risk of homelessness, to the HCHV program.

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

[76] 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.

[77] "Stand Downs are typically one- to three-day events during which VA staff and volunteers provide food, clothing and health screenings to homeless and at-risk Veterans." "VA Homeless Programs, Stand Down Events," Department of Veterans Affairs, accessed April 11, 2024, https://www.va.gov/homeless/events.asp.

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).[78]

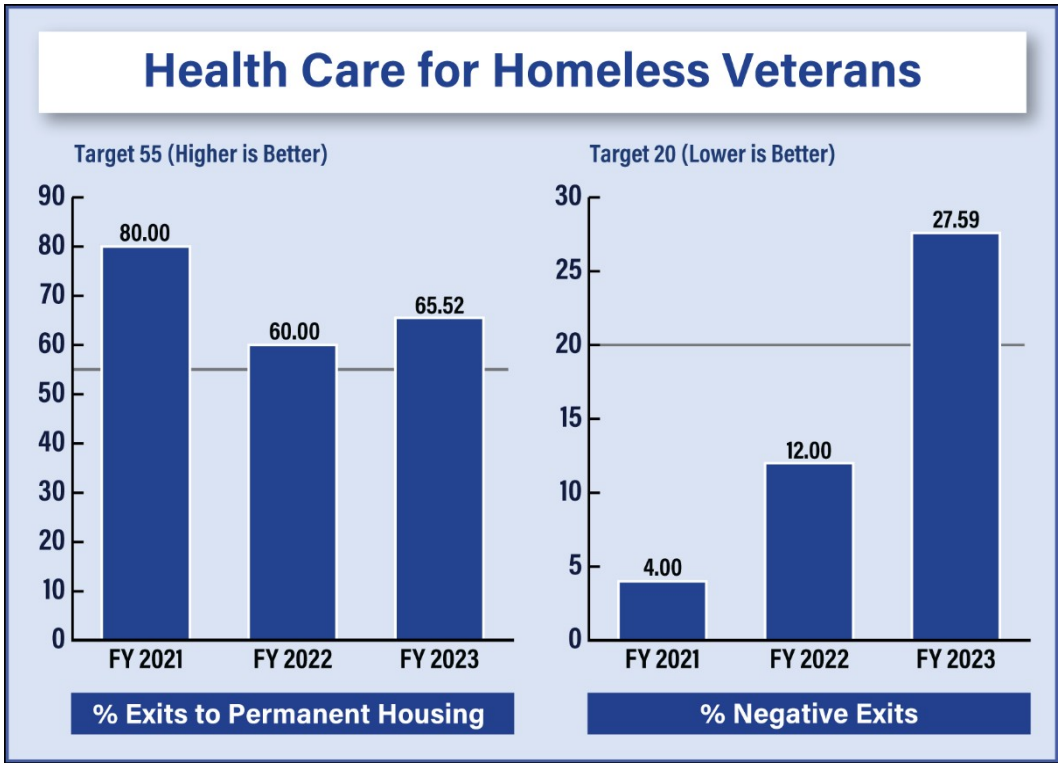

Figure 11. *HCHV program performance metrics.*
Source: VHA Homeless Performance Measures data.

The facility met the HCHV1 target, and program staff attributed it to meeting weekly with community partners to monitor enrolled veterans, resulting in successful permanent housing placements. However, the facility did not meet the HCHV2 target in FY 2023, which the Program Coordinator said the contracted residential facility's employees discharged veterans due to rule violations. Program staff explained the employees were new to their positions, so they guided them on early intervention, including contacting program staff when problems arose to minimize premature discharges.

[78] 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*.

The staff added that enrolling veterans and maintaining their engagement in the program can be challenging. Staff said they previously used Coronavirus Aid, Relief, and Economic Security Act of 2020 funds to buy cell phones for veterans, allowing staff to communicate with them and meet their needs, such as food, shelter, and health services.[79] After the funding ended, staff said they collaborated with community partners to provide cell phones.

Figure 12. *Facility's current community partnerships.*
Source: OIG interview.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[80] 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.[81]

[79] Coronavirus Aid, Relief, and Economic Security Act of 2020, Pub. L. No. 116-136, 134 Stat. 281 (2020).
[80] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report.*
[81] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[82] The facility met the target in FY 2023. Program staff attributed this success to having five veterans justice outreach specialists who cover 15 counties. Staff further explained that the specialists regularly engage in activities, such as outreach to jails and the 10 veterans treatment courts in the area, and collaborate with local law enforcement and other first responders to raise program awareness.[83] They also mentioned that some jails in the service area use the Veterans Re-entry Search Service to identify veterans and connect them to the program.[84]

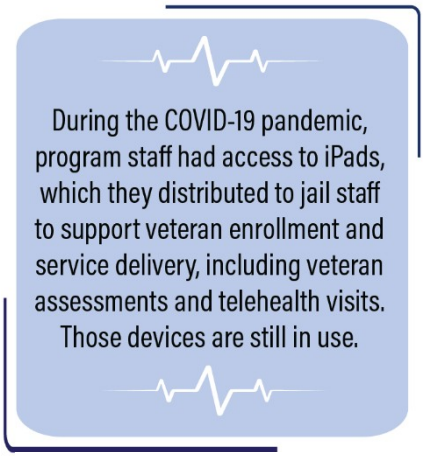

Figure 13. *Veterans enrolled in Veterans Justice Program using iPads. Source: OIG interview.*

Program staff explained the facility had a deflection team, composed of the five specialists, a VA police officer, and a suicide prevention staff member, who train community law enforcement on treatment options, such as the justice program, for veterans to avoid entry into the justice system.[85] Law enforcement and first responders also use the Status Query and Response Exchange System to quickly identify veterans' eligibility and refer them to the program.[86]

[82] 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*.

[83] Veterans treatment courts "effectively integrate evidence-based substance use disorder treatment, mandatory drug testing, incentives and sanctions, and recovery support services in judicially supervised court settings that have jurisdiction over veterans involved in the justice system who have substance use disorders, including a history of violence and post-traumatic stress disorder as a result of their military service." "Veterans Treatment Court Program, Overview," Department of Justice, accessed April 21, 2024, https://bja.ojp.gov/veterans-treatment-court-program.

[84] The Veterans Re-entry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military." "Welcome to the Veterans Re-Entry Search Services," Department of Veterans Affairs, accessed April 11, 2024, https://vrss.va.gov.

[85] "'Deflection' means a collaborative intervention to assist individuals with substance use disorder, mental health disorder, or co-occurring disorders, in which law enforcement or other first responders connect with behavioral health systems to create community-based pathways to treatment, recovery support services, housing, case management, or other services." "Model Law Enforcement and Other first Responder Deflection Act," Legislative Analysis and Public Policy Association, September 2021, https://legislativeanalysis.org/Model-Law-Enforcement-and-Other-First-Responder-Deflection-Act.pdf.

[86] The "Status Query and Response Exchange System (SQUARES) is a VA web application that provides VA employees and external organizations…with reliable, detailed information about Veteran eligibility." "VA Homeless Programs, SQUARES," Department of Veterans Affairs, accessed July 21, 2024, https://www.va.gov/HOMELESS/squares/index.asp.

Meeting Veteran Needs

Program staff explained the needs of enrolled veterans includes substance use disorders treatment, primary and mental healthcare, legal services, and housing and work with community partners to assist in meeting those needs. One program staff member shared an example of working with a veteran who was previously incarcerated for a felony and therefore not eligible for VA healthcare services. The staff member collaborated with a community partner who provided the veteran with temporary housing and access to substance use disorder treatment. As a result, the veteran successfully transitioned to independent housing, opened a construction company, and began participating in community efforts to help homeless individuals.

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."[87] 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.[88]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[89] The facility did not meet the targets in FYs 2021 through 2023.[90] The Housing and Urban Development–Veterans Affairs Supportive Housing Program Coordinator attributed missing the target to previous staffing shortages, which had been resolved, and limited available housing. Staff said they can enroll a veteran into the program in less than a week.

Program staff further explained they lost housing options when local landlords increased rental costs to capitalize on rapid growth and development in the area. Staff said leaders hired a housing specialist in FY 2023 to encourage landlords to rent to veterans. In efforts to expand

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

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

[89] 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*.

[90] The HMLS3 targets were 92 percent, 92 percent, and 90 percent for FYs 2021, 2022, and 2023, respectively. The facility program attained 90 percent, 85 percent, and 80 percent, respectively.

housing availability, the Program Coordinator reported currently working with community partners to build transitional and permanent housing units for veterans on about 10 acres of land, projected to be completed in 2025.

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).[91] The facility's program exceeded targets for FYs 2021 through 2023.[92] Program staff attributed the success to sharing an employment newsletter that provides job-related information, such as updates on job fairs and instructions on building resumes, with VA staff and veterans. Additionally, the program's employment specialist identified potential employers and assisted veterans with obtaining education or skills and applying for jobs online.

Program staff explained transportation is a barrier for some veterans in getting around to places, such as medical appointments. To address this issue, they help veterans apply for discounted public transportation fares and work with community partners to provide rides and bus passes.

The Program Coordinator said program staff have been successful in housing veterans with the support of community partners who supply funds for rental and utility deposits, as well as storage and moving assistance and household and hygiene items. The coordinator reported having a good relationship with the partners, making it easier to get assistance with veterans' needs. For example, program staff requested a baby crib on behalf of a veteran, and the partner provided it the same day.

Conclusion

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

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

[92] The VASH3 targets were 45 percent, 47 percent, and 50 percent for FYs 2021, 2022, and 2023, respectively. The facility program attained 54 percent, 63 percent, and 60 percent, respectively.

OIG Recommendations and VA Responses

Recommendation 1

The Director ensures staff correct deficiencies found during comprehensive environment of care rounds or develop an action plan to address them within 14 business days.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Assistant Director, the Chief of Engineering, the Chief Industrial Hygiene and Safety have reviewed Veterans Health Administration (VHA) Directive 1608(1) Comprehensive Environment of Care Program (CEOC), dated June 21, 2021, and amended September 7, 2023. In response to the recommendation and review of VHA Directive 1608(1), facility leadership added a discussion each week in the Monday edition of the daily "Morning Report" Teams meeting with all department heads to highlight all outstanding Environment of Care (EOC) findings. The format of this discussion specifically lists all EOC items with incomplete action plans, along with the current day count for each as it relates to the 14-day metric. Outstanding items that are approaching the 14-day metric are specifically highlighted and posted for applicable staff to address accordingly. Since implementation of these actions, compliance with closure of EOC deficiencies within 14 business days has remained above 90 percent for two consecutive quarters, 97 percent (464/478) in FY25 Quarter 2 and 93 percent (468/503) in FY25 Quarter 3. The numerator is the number of deficiencies that were addressed within 14 business days, and the denominator is the total number of deficiencies observed. The Chief Industrial Hygiene and Safety and Chief Engineer will continue to monitor through FY25, reporting to the EOC Committee monthly, and the facility will request closure after 90 percent compliance has been sustained for six (6) months.

Recommendation 2

The Director ensures staff conduct fire drills once per shift, per quarter, in each patient area.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Assistant Director, the Chief of Engineering and the Chief Industrial Hygiene and Safety reviewed the process and identified opportunities to improve oversight of fire drill completion. The Industrial Hygiene and Safety manager adopted a Joint Commission tracking matrix document on August 2, 2024, to ensure fire drills for all shifts are completed as required. The facility achieved 100 percent (13/13) compliance in FY25 Quarter 1, 100 percent (16/16) in FY25 Quarter 2, and 100 percent (15/15) in FY25 Quarter 3. The numerator is the number of fire drills completed, and the denominator is the total number of fire drills required. The Chief Industrial Hygiene and Safety and Chief Engineer will continue to monitor through FY25, compliance reports are submitted to Environment of Care Committee monthly, and the facility will request closure after 100 percent compliance has been sustained for six (6) months.

Recommendation 3

Executive leaders ensure staff inspect all medical equipment timely, and equipment has preventive maintenance labels.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Associate Director, Chief of Engineering, and Biomedical Engineering Supervisor reviewed the process for placement of preventative maintenance (PM) stickers. At the time of inspection, there was a PM sticker labeled incorrectly with the completed date rather than the due date, and the conflicting dates on the stickers led to confusion. To correct this issue, PM stickers were standardized between Facilities Maintenance and Biomedical Engineering. Additionally, new PM stickers were implemented throughout Engineering September 1, 2024, and are now color-coded by fiscal year for added visibility in determining if equipment is current on its PM. Medical Equipment PM is reported out quarterly to the Environment of Care Committee. A work order system which tracks due dates for PM has been in place via Maximo since 2016 and in Vista prior to Maximo. The facility has maintained 100 percent compliance with PMs for high-risk medical equipment and non-high risk medical equipment for three consecutive quarters. The facility achieved 100 percent (941/941) compliance for PM completion in FY24 Quarter 4, 100 percent (770/770) in FY25 Quarter 1, and 100 percent (1,959/1,959) in FY25 Quarter 2. The numerator is the number of equipment PMs completed, and the denominator is the total number of equipment PMs due. The Biomedical Engineering Supervisor will continue to monitor through FY25, submit inspection reports to the EOC Committee quarterly until 90 percent compliance has been reached for at least six (6) months.

Recommendation 4

Executive leaders ensure staff properly clean patient care areas in the Emergency Department.

__X__ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

The Associate Director formed a team on July 19, 2024, to include Emergency Department (ED) leadership, Engineering, Industrial Hygiene, Logistics, Environmental Services (EMS), Quality, and Nursing to address the opportunities to improve cleanliness of the Emergency Department. The Chief of Environmental Services and Infection Prevention updated applicable Standard Operating Procedures (SOP), to include SOP 1, Patient Room Cleaning Terminal Discharge dated January 13, 2025, SOP 11, Examination Room dated January 13, 2025, SOP 19, Discharge Isolation Rooms dated January 13, 2025, SOP 20, Patient Room Cleaning Standards, dated December 26, 2024, and SOP 21, Patient Room Occupied Isolation dated January 13, 2025. In addition to the above, the main ED floors were stripped and waxed on March 27, 2025, and all reusable curtains were replaced on August 2, 2024, with disposable curtains. The ED fast-track floors will be stripped and waxed upon arrival of new equipment that is anticipated in July 2025. To support ongoing compliance, on July 29, 2024, the ED nursing staff began completing the weekly Environment of Care (EOC) rounding checklists and on June 13, 2025, the EMS staff started attending weekly ED huddles to gain feedback from frontline ED staff. On July 9, 2025, EMS staff started a cleaning audit to track and document compliance. The numerator will be the number of areas that were properly cleaned, and the denominator will be the total number of areas observed. The Nurse Manager of the ED or the Chief of EMS will be completing the audits, and the results will be reported to the EOC Committee monthly until 90 percent compliance is met for six (6) months.

Recommendation 5

Executive leaders ensure staff keep exit pathways free from obstructions.

__X__ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

The Chief of Emergency Medicine, Chief of Logistics, and Engineering collaborated to identify contributing factors and solutions to correct the obstruction of exit pathways. During the Office

of Inspector General visit, the Emergency Room was actively undergoing construction. Since then, phase 1 of the Emergency room remodel was completed March 17, 2025, and a new space has been identified for storage. Additionally, Logistics initiated a life cycle of equipment review on May 20, 2025, and this will be completed on an annual basis to ensure that equipment no longer needed is appropriately removed from the area. To support ongoing compliance, ED staff started completing weekly EOC rounding checklists on July 29, 2024, which include verification that exit pathways are not obstructed. Closure will be requested when 90 percent compliance has been sustained for six consecutive months. The numerator will be the number of exits that were not obstructed, and the denominator will be the total number of exits observed. The Nurse Manager of the ED will be completing the audits, and the results will be reported to the EOC Committee monthly.

Recommendation 6

The Director ensures staff develop service-level workflows for the communication of test results.

__X__ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

The Chief of Staff, the Director of Quality, and Systems Redesign reviewed VHA Directive 1088(1) Communicating Test Results to Providers and Patients, dated July 11, 2023, and amended September 20, 2024. Medical Center Policy (MCP) 11-115 Communicating Test Results to Providers and Patients was updated on March 26, 2025, and is in the process of being updated to include all elements, service level workflows, and processes to monitor communication of test results to patients per VHA guidance.

Recommendation 7

The Director ensures staff implement a facility-wide process to monitor providers' communication of urgent, noncritical test results to patients, and report compliance to an appropriate oversight committee.

__X__ Concur

____ Nonconcur

Target date for completion: April 30, 2026

Director Comments

The Chief of Staff and the Director of Quality reviewed VHA Directive 1088(1) Communicating Test Results to Providers and Patients, dated July 11, 2023, and amended September 20, 2024. The External Peer Review Program (EPRP) committee reports to the Quality, Safety, and Value Committee (QSV) quarterly, with the first report out occurring on November 26, 2024. Quality managers will perform a random review of 50 outpatient test results from 50 unique outpatients beginning September 18, 2025. Compliance will be monitored as a standing agenda item at the QSV Committee with the first report occurring on October 28, 2025. Monitoring will continue until 90 percent or greater compliance is met for six (6) consecutive months. The numerator will be the total number of abnormal or non-critical test results communicated in accordance with VHA Directive 1088(1). The denominator will be the total number of abnormal or non-critical test results reviewed.

Recommendation 8

Executive leaders ensure staff implement actions from root cause analyses timely, monitor actions for effectiveness and sustained improvement, and report compliance to an appropriate oversight council.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

All historical Root Cause Analysis (RCA) actions and outcome measures, most of which were generated by RCA teams between 2017 to 2019, were investigated and finalized by current Patient Safety Managers. There are no remaining delinquent actions nor outcome measures. The finalization of delinquencies was completed on October 30, 2024. An RCA action was deemed finalized pursuant to a memo dated July 18, 2024, by the facility Medical Center Director to include all RCA actions and outcomes to be reviewed thoroughly by the Patient Safety Managers. The criteria to close an RCA action included an issue no longer relevant for clinical or administrative reasons, actions taken under a subsequent RCA, systems/programs that no longer exist, systems/program changes that occurred which make an action non-applicable, and an action or initiative outside of the RCA process which occurred making the action non-applicable.

To support ongoing implementation of timely RCA actions and outcome measures, the facility implemented a new RCA tracking tool that generates regular, automated reminders to those staff members assigned responsibility for RCA actions and/or outcome measures. The RCA tracking tool was implemented on October 2, 2024. Members of the executive leadership team have read-only access to the tracker to stay apprised of all assigned actions and outcome measures. If

actions or outcome measures become delinquent, the software automatically notifies the executive leadership team on the first day of delinquency so that they can support resolution.

Compliance will be reported to the facility QSV Committee beginning July 22, 2025, and the facility will request closure when those minutes demonstrate sustained compliance and oversight for six (6) consecutive months.

Recommendation 9

The Director evaluates the patient safety program, including staffing, to ensure executive leaders receive meaningful patient safety information and improvement project data.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The Chief of Quality and the Medical Center Director reviewed Veterans Health Administration (VHA) Directive 1050.01(1) VHA Quality and Patient Safety Programs, dated March 24, 2023, and amended March 5, 2024, and Medical Center Policy (MCP) 00-07, Patient Safety Program, dated August 2021. VHA Directive 1050.01(1) requires that Medical Center Directors select and appoint a minimum of 1.0 FTE for the VA medical facility Patient Safety Manager. The facility has exceeded that requirement by maintaining at least 2.0 FTE dedicated to the Patient Safety program. Until recently in June 2025, the facility had 3.0 FTE dedicated to Patient Safety. Approval has been granted for the facility to backfill the open Patient Safety Manager position so the facility can continue a robust patient safety program in support of the upcoming Electronic Health Record Modernization in 2026.

The Chief of Quality evaluated the functionality of the patient safety program; specifically, how executive leaders receive meaningful patient safety information and improvement project data. An opportunity was identified to improve the communication of Root Cause Analysis (RCA) action and outcome measure timeliness. Therefore, the Patient Safety team implemented a new RCA tracking tool that generates regular, automated reminders to those staff members assigned responsibility for RCA actions and/or outcome measures. Members of the executive leadership team have read-only access to the tracker to stay apprised of all assigned actions and outcome measures. If actions or outcome measures become delinquent, the software automatically notifies the executive leadership team on the first day of delinquency so that they can support resolution. Additionally, the facility initiated a weekly update on December 10, 2024, in the leadership morning report to enhance leadership's visibility of outstanding Joint Patient Safety Reports (JPSRs) and support timely resolution. The patient safety team began to report monthly information and improvement project data on July 23, 2024, to facility Quality, Safety and Value

(QSV) Committee, co-chaired by the Medical Center Director. The Patient Safety Managers (PSMs) in tandem with the High Reliability Coordinator created monthly Patient Safety forums which began on August 1, 2024, across the medical center. Also, the PSMs began to participate in daily nursing leadership huddles to review JPSRs and any safety concerns on December 10, 2024.

The PSMs will be briefing at the Executive Leadership Council (ELC) on August 12, 2025, to provide collaboration as requested by leadership.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs.[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 from July 16 through 18, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

[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 two VSOs: Disabled American Veterans and the Marine Corps League.

[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: June 26, 2025

From: Acting Network Director, VA Healthcare System Serving Ohio, Indiana, and Michigan

Subj: Healthcare Facility Inspection of the VA Cincinnati Healthcare System in Ohio

To: Director, Office of Healthcare Inspections (54HF05)

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

1. I have reviewed the response to OIG's Healthcare Facility Inspection of the VA Cincinnati Healthcare System in Ohio.
2. I concur with the response and action plans submitted by the Cincinnati VA Medical Center Director.
3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Beth Lumia, MSW

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 24, 2025

From: Acting Medical Center Director, VA Cincinnati Healthcare System (539)

Subj: Healthcare Facility Inspection of the VA Cincinnati Healthcare System in Ohio

To: Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Cincinnati VA Medical Center. We appreciate the opportunity for this review as we continue to improve for our Veterans.
2. I have reviewed the report and concur with all the recommendations. Action plans have been developed or implemented in the Director's comments.

(Original signed by:)

James R. Hall
Acting Medical Center Director

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