US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Alexandria Healthcare System in Pineville, Louisiana

Healthcare Facility Inspection	24-03418-205	September 11, 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 Alexandria Healthcare System (facility) from November 5 through 6, 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. Executive leaders identified system shocks as two incidents caused by hurricanes that led to patient evacuations to other medical facilities within the Veterans Integrated Service Network (VISN).[2] In one incident, the contracted transportation service was unreliable, so leaders used other methods, such as VA police, to transport patients.

The OIG reviewed All Employee Survey scores from fiscal years 2022 through 2024 and found leaders' communication had improved.[3] Executive leaders share information through weekly newsletters, informational video clips on televisions throughout the facility, and veteran 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] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[3] 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.

employee town halls. They also visit work areas, including outpatient clinics, to speak with staff about their concerns and involve them in projects to improve patient care.

Respondents to an OIG questionnaire indicated most employees feel comfortable suggesting actions to improve their work environment and reporting concerns. Patient advocate and veterans service organization questionnaire respondents indicated that executive leaders had effectively addressed concerns about appointment availability and parking.[4] For example, veterans had concerns about the distance from the parking lot to the main entrance, and therefore, leaders use shuttles to transport veterans from the parking spaces.

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.

After successfully navigating to the facility using directions from its website, the OIG observed signs directing veterans from the parking areas to the main entrance. The main entrance had seating, natural lighting, available wheelchairs, and an information desk where volunteers assisted veterans as needed. Facility staff acknowledged multiple unscheduled outages of rented boilers and informed the OIG they had installed new boilers, but they were not operational because personnel had not yet received training to use them.

During the physical inspection, the OIG observed that staff stored clean and soiled equipment together in areas shared by the inpatient unit and Community Living Center.[5] The Community Living Center had been temporarily relocated because of a mold issue. Facility leaders explained they were working on renovation plans. The OIG did not make a recommendation because staff separated the equipment during the site visit.

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

[4] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/. 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] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed June 3, 2025, https://www.va.gov/VA_Community_Living_Centers.asp.

for improvement. The OIG found staff had developed a policy and service-level workflows (which describe team member roles in the communication process) for communicating test results to providers and patients. The OIG reviewed fiscal year 2024 performance data and found only 39.4 percent compliance with the requirement for providers to communicate test results needing action to patients within seven calendar days from the date the results became available. In addition, the primary care chief shared that because providers communicate results to patients in different ways, it was difficult to find the documentation. The OIG recommends facility leaders ensure ordering providers communicate test results to patients timely.

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.[6]

At the time of the inspection in November 2024, the facility had nine vacancies in primary care positions. Recruitment difficulties stem from the facility's rural location, competitive private sector salaries, and preferences for remote nursing positions. To attract candidates, facility and primary care leaders offer hiring incentives, such as recruitment bonuses and student loan repayment options. Primary care leaders added they are almost fully staffed.

Primary care leaders and staff said providers received numerous notifications in electronic health records that disrupted their workflow. Primary care leaders educated providers on how to manage them and reduced the unnecessary notifications by 25 percent. The primary care chief and staff said the PACT Act did not significantly affect efficiency.

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 into the programs and how well they meet veterans' needs. The program coordinator said the communities use a shared list to track outreach efforts and identify homeless veterans to enroll in the program, which contributes to housing more veterans.

Program staff identified a challenge in finding landlords willing to accept Housing and Urban Development–Veterans Affairs Supportive Housing program vouchers. Staff said they engaged with landlords and housing authorities to help veterans interested in shared housing arrangements.

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

Staff also identified veterans' complex medical and mental health needs as risks to maintaining permanent housing. In addition to helping these veterans engage in treatment, staff worked with community agencies to offer veterans social activities to reduce the risk of loneliness. For example, staff collaborated with wildlife agencies, fisheries, zoos, and museums to arrange social outings. The Lead Case Manager highlighted veterans who have gone through the program then purchased their own homes as evidence of the Housing and Urban Development–Veterans Affairs Supportive Housing program's success.

What the OIG Recommended

The OIG made one recommendation.

1. Facility leaders ensure providers who order tests communicate the results to patients timely.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, and the response within the body of the report for the full text of the directors' comments). The Director requested to close the recommendation. The OIG reviewed the documents provided and found staff did not implement and monitor corrective actions 90 percent of the time for six consecutive months. The OIG will follow up on the planned actions for the open recommendation until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Alexandria Healthcare System
Pineville, Louisiana
Level 3-Low Complexity
Rapides Parish
Hospital Referral Region: Alexandria

Description of Community

POPULATION

Female **263,815**	Male **267,220**
Veteran Female **4,770**	Veteran Male **32,796**

Homeless - State **7,373**
Homeless Veteran - State **322**

MEDIAN INCOME

$42,598

EDUCATION

81% Completed High School
40% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **269**

SUBSTANCE USE

29.5% Driving Deaths Involving Alcohol
20.3% Excessive Drinking
169 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	167,607
Carpool	17,157
Other Means	5,125
Work at Home	5,024
Walk to Work	4,388
Public Transportation	1,455

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**42.5 Minutes, 36.5 Miles**
Specialty Care	**63.5 Minutes, 56.5 Miles**
Tertiary Care	**190.5 Minutes, 195 Miles**

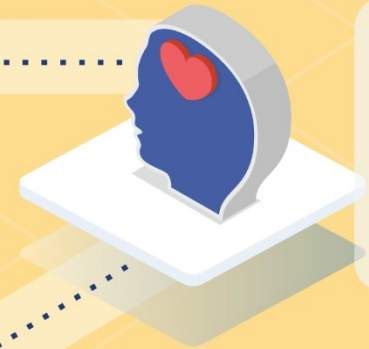
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **9,728**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	36%
<65 without Health Insurance	16%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

8,345

120 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.69 Days

30-DAY READMISSION RATE

18%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
19	29

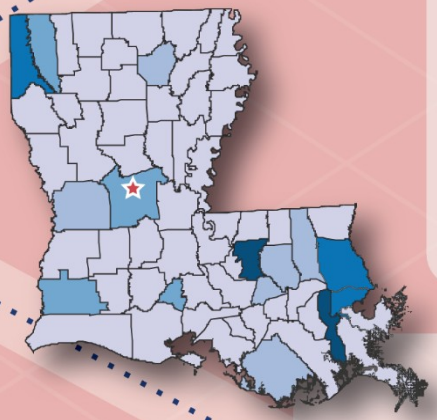
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	33K
Unique Patients VA Care	30K
Unique Patients Non-VA Care	22K

COMMUNITY CARE COSTS

Unique Patient $21,433	Outpatient Visit $298
Line Item $602	Bed Day of Care $223



STAFF RETENTION

Onboard Employees Stay <1 Yr	9.53%
Facility Total Loss Rate	13.69%
Facility Retire Rate	3.42%
Facility Quit Rate	8.47%
Facility Termination Rate	1.45%

★ VA MEDICAL CENTER

VETERAN POPULATION

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. 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

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

patient safety and care.

High Reliability Organization Framework

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

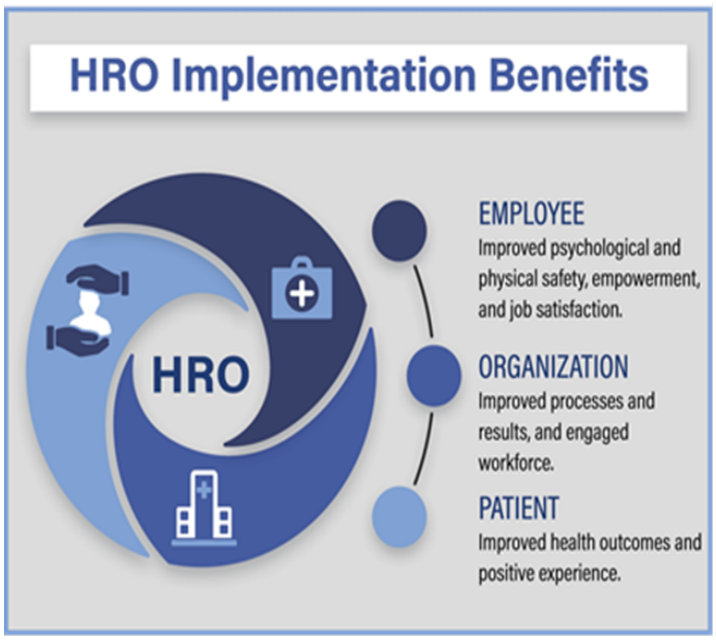


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations.

PACT Act

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

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

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

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

[11] Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022. Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

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

Content Domains

Figure 3. *Healthcare Facility Inspection'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(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; 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 Alexandria Healthcare System (facility) began as a seminary and military academy in January 1860. The campus evolved into a National Guard training area and tuberculosis hospital before becoming a permanent veterans' hospital on December 6, 1929. The facility had 91 operating beds (38 hospital, 46 Community Living Center, and 7 domiciliary), and a fiscal year (FY) 2023 medical care budget of approximately $464 million.[13]

The OIG conducted an inspection of the facility during the week of November 4, 2024. At that time, the facility's executive leaders consisted of the Director, Associate Director, Chief of Staff, and Associate Director for Patient Care Services. The newest member of the team was the Associate Director, assigned in June 2024; the Director had been in place since January 2016; and the Chief of Staff had served in the role since 2020.

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

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed June 3, 2025, https://www.va.gov/VA_Community_Living_Centers.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed June 3, 2025, https://www.va.gov/homeless/dchv.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.

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] 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.

During an interview, executive leaders described two events involving patient evacuations as significant system shocks. A few years prior, a hurricane caused an engineering system failure, and hospitalized patients had to be evacuated to other medical facilities within the Veterans Integrated Service Network (VISN).[19] In a second evacuation event due to a hurricane, some of the contracted companies failed to provide transportation. Leaders informed the OIG they used other modes of transportation, such as VA police, to relocate patients within 24 hours.

Additionally, the Chief of Staff reported that in the weeks prior to the site visit, staff had temporarily relocated the Community Living Center because of a mold issue, but executive leaders did not identify any significant effect on the center's operations. A leader explained that renovations to the center's original location were in the design phase.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22]

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

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

[19] VA 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/.

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

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

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

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with employees, and shared information.[23]

Survey data showed a positive trend for senior leader communication and information sharing scores from FYs 2022 through 2024.[24] During an interview, executive leaders said they send weekly newsletters and air video clips on televisions throughout the facility to share information with employees. Leaders also hold veteran and employee town halls as other means of communication. Employees broadcast veteran town halls on social media so those who are unable to attend in person could ask questions. Employee town halls use the Microsoft Teams application, allowing those at community-based outpatient clinics to participate remotely.[25] Leaders described being intentional about fostering two-way communication with veterans and employees during these meetings.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[26] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[27] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

Questionnaire responses indicated most employees feel comfortable suggesting actions that could improve their work environment. Executive leaders engaged with employees and department leaders by walking through work areas to increase visibility and hear from them about their concerns. Employees and executive leaders share information related to these

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

[24] Senior leader goal communication measures leaders' communication of the organization's goals, and senior leader information sharing measures how satisfied employees are with the information received from leaders. "2020 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

[25] Microsoft Teams is a messaging application used by organizations to meet, collaborate, and share files. "What is Microsoft Teams?," Microsoft, accessed July 1, 2025, https://support.microsoft.com/what-is-microsoft-teams. "A community-based outpatient clinic (CBOC) is a VA-operated, VA-funded, or VA-reimbursed site of care, which is located separate from a VA medical facility. A CBOC can provide primary, specialty, subspecialty, mental health, or any combination of health care delivery services that can be appropriately provided in an outpatient setting." VHA Handbook 1006.02, *VHA Site Classifications and Definitions*, December 30, 2013.

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

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

interactions in the weekly newsletter. The Director added that executive leaders also visit the community-based outpatient clinics to engage with employees.

Additionally, OIG questionnaire respondents identified caring for veterans as the primary reason for continuing to work at the facility. Executive leaders highlighted employees' commitment to veterans, demonstrated through actions like nurses from the Alzheimer's unit staying with patients during transfers to another facility location to ensure continuity and familiarity.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The facility's psychological safety scores had trended upward from FYs 2022 through 2024. Additionally, the OIG questionnaire showed most respondents feel comfortable reporting patient safety or employee concerns. Executive leaders said they involve employees in process improvements, which demonstrate they value their input on how to improve patient care. The Director added that employees approaching leaders with concerns during their visits was another indicator of psychological safety.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Answers to the OIG questionnaires indicated patient advocates and VSOs feel executive leaders are responsive to veterans' concerns. VSO respondents reported executive leaders effectively addressed veterans' most common complaints, such as lack of appointment availability and issues with parking. When asked about parking, the Director explained that veterans had a concern about the distance from the parking spaces to the buildings. Therefore, leaders offered a shuttle service to transport veterans to the main entrance.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[30] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 4. *Facility photo.*
Source: "Alexandria VA Medical Center," Department of Veterans Affairs, accessed December 31, 2024, https://www.va.gov/alexandria-health-care/locations/alexandria-va-medical-center/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[31] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[32]

[30] VHA Directive 1608(1).

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

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

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.

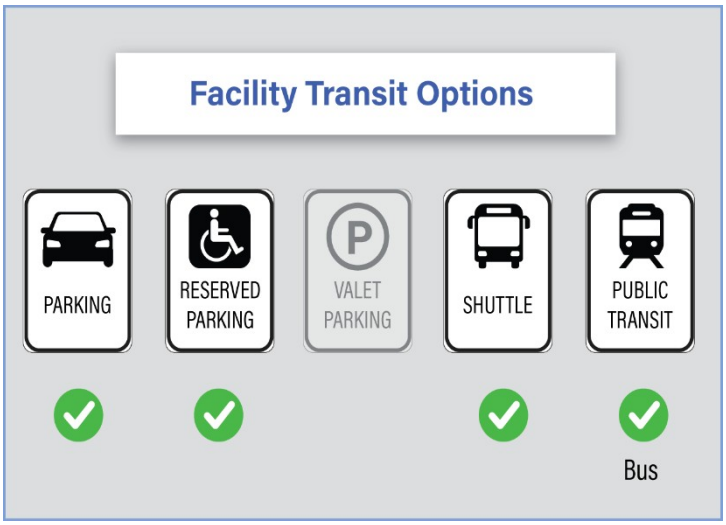

Figure 5. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

The OIG used directions on the facility's public website to reach the site, finding the instructions easy to follow. The OIG noted signs led to the parking areas, which had adequate lighting and sufficient accessible spaces for those with disabilities. The facility has shuttle services available to transport veterans between parking lots and buildings.

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.[33]

The OIG noted signs marking the main entrance. The entrance area was welcoming, with natural lighting, and had ample seating and wheelchairs available. Volunteers at the information desk provided coffee and escorted veterans to their destinations, if needed.

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.[34]

[33] 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*.

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

The OIG observed a large, color-coded map located at the main elevator and clear directional signs throughout the facility. The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] A staff member confirmed that assistive devices are available for veterans with visual and hearing impairments. Another staff member said a project to improve signs is underway; signs will include braille and comply with standards for serving veterans with color-blindness and memory challenges.

Figure 6. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

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 VHA's guidelines.[36] The OIG reviewed documentation showing the facility had two navigators. One navigator reported communicating to veterans about screenings through various means, including letters, a town hall, and informational handouts. Additionally, information desk volunteers said they were aware of the screenings and directed veterans with questions to the Urgent Care Clinic for further information.

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.[37] The OIG analyzed facility

[35] 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.

[36] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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

data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The facility's most recent OIG comprehensive healthcare inspection report, published in September 2023, had no recommendations that involved the environment of care.[38] The OIG also reviewed issue briefs and four reports related to the facility's boilers. The co-chair of the Comprehensive Environment of Care Committee told the OIG that a new construction project, which included boiler replacements, was in progress. As a temporary measure during the construction, the facility used contractor-operated boilers but replaced them with temporary units while they installed the new permanent boilers due to multiple unscheduled outages in FY 2024. The chair explained the new boilers were installed but not operational because staff had not yet received training to use them.

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.

In addition to the inpatient unit and Community Living Center, the OIG inspected the urgent and primary care clinics, finding all areas clean and without privacy concerns. However, because of the mold issue discussed previously in the Culture domain, the Community Living Center and inpatient unit temporarily shared a hallway and storage space. The OIG found staff stored clean and dirty equipment together in the area, which is an infection risk. Once the OIG identified the issue, staff separated the items. Because staff resolved the issue, the OIG did not make a recommendation.

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.

[38] VA OIG, *Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana*, Report No. 22-00073-223, September 29, 2023.

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.[39] 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.[40] 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.

Based on an interview and documents, the OIG found staff had developed a policy and service-level workflows (which describe team member roles in the communication process) for communicating these results to ordering providers or designees and their patients. VHA requires staff to communicate test results needing action to patients within seven calendar days after the results became available.[41] Based on performance data for FY 2024, the OIG determined the facility met this requirement only 39.4 percent of the time.

During an interview, the Chief of Staff described receiving a weekly email with test result alerts for all services and communicating with individual providers to address any excess alerts. The primary care chief explained that because providers communicate results to patients in several ways (face-to-face, letters, phone calls, and secure messages), locating the documentation was challenging. The chief also said they implemented new computer software at community-based outpatient clinics to assist with documenting the communication and automatically generate letters for staff to mail to patients. The chief shared that initial software trials showed positive results, and leaders plan to implement it facility-wide. The OIG recommends facility leaders ensure providers who order tests communicate the results to patients timely.

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

[40] 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.

[41] VHA Directive 1088(1).

Action Plan Implementation and Sustainability

Figure 7. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[42] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The most recent OIG comprehensive healthcare inspection report had no open recommendations.[43] Quality department staff said they track and discuss improvement actions at various meetings, including daily administrative meetings and the Director's morning meeting, to ensure staff complete corrective actions in a timely manner and sustain improvements.

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.[44] 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.[45] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Facility staff said they review patient safety and patient advocate reports daily and recognize staff with Good Catch awards for strong reporting efforts.[46] They also share lessons learned through the facility newsletter, facility and VISN-level meetings, and town halls.

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

[43] VA OIG, *Comprehensive Healthcare Inspection of the Alexandria VA Health Care System in Pineville, Louisiana*.

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

[45] VHA Directive 1050.01(1).

[46] "Good catches occur when an individual(s) intercepts a potential safety event before harm occurs." Department of Veterans Affairs, *VHA Good Catch Recognition Program Instructional Guide and Toolkit V 1.0*, January 2024.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[47] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[48] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[49] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

During the week of the inspection, the facility had nine vacant primary care positions.[50] When the OIG inquired about filling the positions, the Chief of Staff said it is difficult attracting providers to the facility's rural location, and private sector employers offer more competitive pay. The Associate Director for Patient Care Services added that recruiting primary care nurses is challenging because many nurses prefer remote positions.

Facility and primary care leaders use hiring incentives, such as recruitment bonuses and the Education Debt Reduction Program, to attract candidates. The Associate Director for Patient Care Services described targeted efforts to recruit nurses by holding job fairs, organizing career days at universities, and hiring a dedicated nurse recruiter. Primary care leaders considered these actions successful, saying they had been operating at 50 percent staffing levels the previous year and were currently almost fully staffed.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[51] The OIG

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

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

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

[50] Facility staff identified the vacancies as five medical support assistants, one registered nurse, one licensed practical nurse, one provider, and the deputy chief of primary care.

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

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

The OIG found that two physician panels and one non-physician panel exceeded VHA's expected size.[53] The Patient Centered Management Module Coordinator highlighted meeting with the primary care chief to analyze panel data and ensure the sizes remain manageable.[54] To help manage the workload, primary care leaders said they hired contract staff to work as needed. They also hold weekend clinics to accommodate more patients and offer overtime pay to non-physician providers. A primary care nurse described the workload as reasonable.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[55] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

During interviews, primary care leaders and staff stated the high volume of clinical alerts (test result notifications in electronic health records) disrupted workflows and reduced efficiency. When the volume of alerts becomes excessive, providers may experience alert fatigue and miss critical results. The primary care chief reported working with the facility's informatics team to identify unnecessary alerts and decrease the total number of alerts by 25 percent, allowing providers to focus on patient care. Additionally, the chief said primary care leaders and informatics staff educated providers on managing clinical alerts and using a decision support tool to help them communicate results to patients. The Chief of Staff reported receiving weekly status reports on alerts for all providers and helping them address issues, if needed.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that veteran enrollment decreased slightly between FYs 2021 and 2022 but increased during FY 2024. The primary care chief and staff said the PACT Act did not significantly affect the team's functioning or efficiency.

[52] VHA Directive 1406(2).

[53] VHA's baseline capacity for panels is 1,200 patients for physicians and 900 for non-physician providers. VHA Directive 1406(2).

[54] The Patient Centered Management Module is a VHA web-based application that collects data from facilities and patient panels to track, find cases, and make comparisons nationwide. VHA Directive 1406(2).

[55] VHA Handbook 1101.10(2).

VETERAN-CENTERED SAFETY NET

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG analyzed enrollment and performance data and interviewed program staff.

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community based residential programs for specific needs such as treatment for serious mental illness or substance use.[56]

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).[57] 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."[58]

The HCHV Program Coordinator told the OIG the facility was exempt from the HCHV5 measure in FYs 2022 and 2023 due to the small number of homeless veterans in the area. When the exemption ended in FY 2024, the program exceeded the target. The coordinator attributed this success to engaging and educating people in community organizations, such as churches, libraries, and police departments, about the homeless programs, which increased referrals. The facility compiled a book that includes information on community hospitals, food

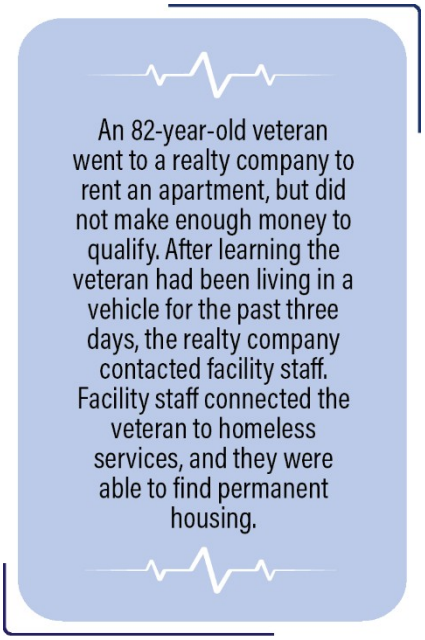

Figure 8. *Success story of veteran engagement.*
Source: OIG questionnaire response.

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

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

[58] 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.

resources, and clothing banks to help homeless veterans who may not be enrolled in the program find resources they need.

The coordinator also said program staff participate in the annual point-in-time count. Staff told the OIG they believed the count underrepresented the number of homeless veterans because it occurred only one night per year. They further explained the count information helps determine the homeless services offered in the community and an underrepresentation could limit resources.

Program staff said they identify homeless veterans through street and community outreach and referrals from facility staff.[59] Staff also said street outreach, during which they provide food, clothing, tents, or other items, is one of the most important aspects of the program because it establishes veterans' trust with VA staff. They also use a by-name list to track outreach, engagement, and progress toward placing veterans in permanent housing.[60] The coordinator credited using the list for the region's federal recognition as having effectively ended veteran homelessness.[61]

[59] VHA defines street outreach as "outreach to Veterans experiencing unsheltered, street homelessness taking place in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." Community outreach takes "place in community-based settings such as shelters, meal sites, homeless Veteran Stand Down events, job fairs, resource and referrals centers, and other community outreach events." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[60] A by-name list is a tool community organizations use to more rapidly house unsheltered veterans. "Veteran Master List Template and Benchmark Report Generation Tool," HUD [Housing and Urban Development] Exchange, accessed November 19, 2024, https://www.hudexchange.info/resource.

[61] The designation from the US Interagency Council on Homelessness means that when veterans become homeless, the community has the resources to support veterans in accessing resources and immediate shelter and swiftly move toward permanent housing. "Benchmarking Progress in Ending Veteran Homelessness, A USICH [US Interagency Council on Homelessness] Initiative," Department of Veterans Affairs, accessed November 21, 2024, https://www.va.gov/homeless/USICHbenchmarking.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).[62] The facility met the HCHV1 and HCHV2 targets from FYs 2022 to 2024. The coordinator and staff explained they meet with enrolled veterans multiple times per week to increase rapport and trust.

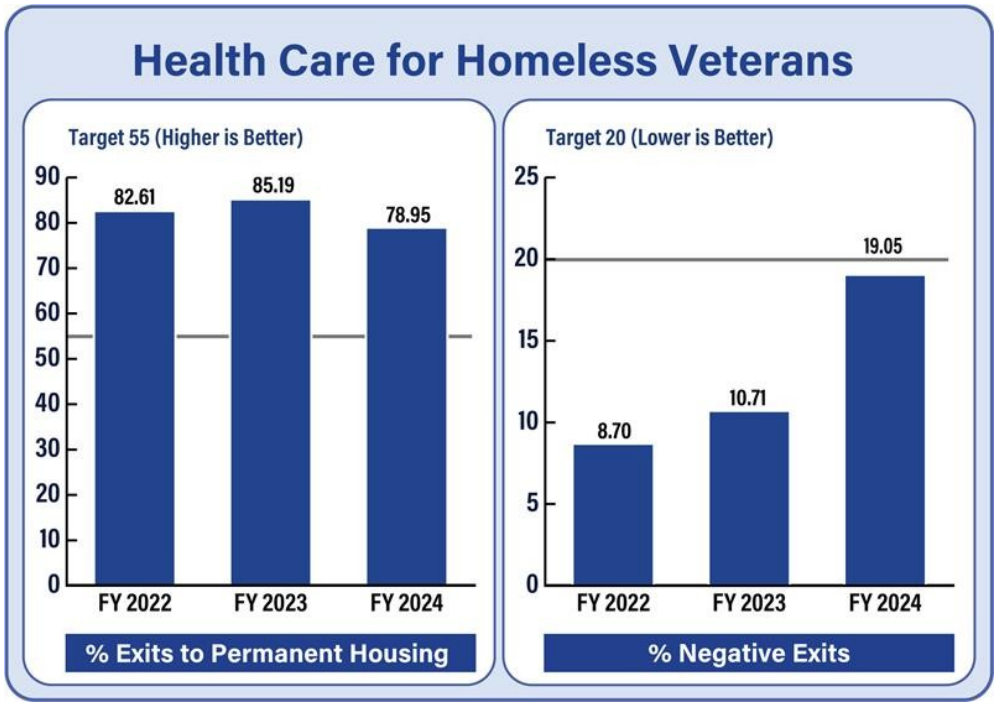

Figure 9. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

Staff refer veterans to specialized programs for needs like substance abuse treatment. Staff said they invite all treatment providers to team meetings and ask veterans at each meeting if the program is meeting their needs.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for

[62] 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*.

veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[63] 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.[64]

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).[65] The facility did not meet the targets in FYs 2022 through 2024. Program staff described challenges meeting the measure because of complex medical and mental health needs that affected some veterans' ability to remain housed. In response, staff said they helped veterans access specialized housing, such as assisted living facilities.

Staff identified other barriers to permanent housing, such as locating landlords willing to accept the voucher amount and limited availability of one-bedroom apartments. The Lead Case Manager shared examples of partnerships with landlords that helped address these barriers. For example, some landlords proactively notified program staff about other landlords with housing vacancies who accept the vouchers. Additionally, staff said they engaged with landlords and housing authorities to connect veterans interested in shared housing arrangements. Staff also helped veterans obtain move-in payment assistance from community agencies.

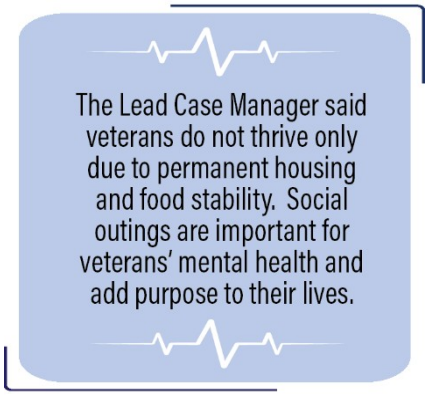

Figure 10. *Best practice for veteran engagement and meeting their needs. Source: OIG interview.*

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[66] The facility exceeded the target in FYs 2022 through 2024. The Lead Case Manager credited this success to the Employment Specialist's work to engage veterans in the program, clarify their

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

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

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

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

employment goals, and ensure staff enter accurate employment data into the documentation system.

The manager also said staff work with community partners, such as laundry services, veterinary and grooming facilities for service animals, food markets, and furniture resources to help meet needs. To support veterans' social needs, staff partnered with wildlife agencies and fisheries, zoos, and museums to provide opportunities for social outings. According to the manager, these activities reduced loneliness and increased veterans' likelihood of maintaining permanent housing. The manager stated positive feedback from veterans and families, as well as the number of veterans who successfully completed the program and went on to purchase their own homes, demonstrated program success.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[67] 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.[68]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[69] The facility exceeded the target in FYs 2023 and 2024. The Veterans Justice Outreach Specialists said they educate local law enforcement, jail, and court staff throughout the service area about homeless programs and VA services.

Staff stated they work with the veterans treatment court in the service area, and the outreach specialists added they worked with other specialized courts as well, including drug and behavioral health treatment and family courts.[70]

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

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

[69] 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*.

[70] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Program staff also shared the facility had a written agreement with the Louisiana Department of Veterans Affairs and the Louisiana Department of Public Safety and Corrections enabling prison, jail, and court staff to use a VA web-based tool to locate veterans in the criminal justice system.[71] Staff said this agreement helped them identify more incarcerated veterans and improved their access to VA health care and benefits.

Veterans Justice Program staff assess the treatment needs of veterans awaiting court proceedings. In many cases, staff request that judges allow veterans to begin treatment before their hearing. As a result of their efforts, staff estimated that up to 90 percent of veterans in the program started or completed treatment prior to court proceedings. Otherwise, veterans would remain incarcerated until their hearing, or treatment would not begin until mandated by a judge at that time.

Figure 11. *Best practice for meeting veteran needs. Source: OIG analysis of documents and interviews.*

Meeting Veteran Needs

Program staff said lack of transportation was an obstacle to veterans engaging in treatment. The outreach specialists clarified that in rural parts of the service area, where public transportation or rideshare services were unavailable, they used VA transportation services or transported veterans themselves, when needed. They also helped veterans access telehealth services. Other program staff highlighted the Justice Program's effectiveness as demonstrated by an increased number of veterans referred to the program and ongoing collaboration with the community.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided a recommendation related to providers communicating test results to patients. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

[71] The Veterans Re-Entry Search Service is a VA tool to help criminal justice systems staff identify veterans and alert Veterans Justice Program staff. Department of Veterans Affairs, *Veterans Re-Entry Search Service (VRSS)*, accessed November 22, 2024, https://www.va.gov/HOMELESS/docs/.pdf.

OIG Recommendations and VA Response

Recommendation 1

Facility leaders ensure providers who order tests communicate the results to patients timely.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Chief of Staff ensures compliance with the communication of test results needing action to patients within seven calendar days. The Chief of Quality and Patient Safety or Designee (QPS) implemented an audit on the follow-up and communication of test results needing action to patients within seven calendar days. Thirty randomized charts are being audited quarterly. The chart audits are performed by QPS staff. The monitoring and sustainment included reporting the audits to the Executive Committee of Medical Service (ECMS) committee. The timeframe for the audit review monitoring started with charts from October 2024 (Qtr.1 2025) through July 2025 (Qtr. 3 2025) interval. The target measure for completion was set for 80 percent compliance or above achievement for two consecutive quarters. The outcome for quarter 1 was measured at 61 percent compliance. The outcome for quarter 2 was measured at 80 percent compliance. The outcome for quarter 3 was measured at 86 percent compliance. We request closure of this item as the target goal has been met for two consecutive quarters (ECMS reports attached).

Numerator: Number of Charts with Veterans notification documented within required timeframes.

Denominator: Total number of charts reviewed.

OIG Comments

The facility submitted documents and requested to close the recommendation. The OIG reviewed the documents and found staff did not comply with requirements to implement and monitor corrective actions 90 percent of the time for six consecutive months. The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Appendix A: Methodology

Inspection Processes

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

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from November 5 through 6, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

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

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

scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides 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: August 5, 2025

From: Interim Network Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Facility Inspection of the VA Alexandria Healthcare System in Pineville, Louisiana

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

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

1. The South Central VA Health Care Network (10N16) has reviewed and concurs with the facility's response to the one (1) recommendation contained in the draft report of the Healthcare Facility Inspection of the VA Alexandria Healthcare System in Pineville, Louisiana.

   (Original signed by:)

   Fernando O. Rivera, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 30, 2025

From: Director, VA Alexandria Healthcare System (502)

Subj: Healthcare Facility Inspection of the VA Alexandria Healthcare System in Pineville, Louisiana

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Alexandria VA Health Care System in Pineville, Louisiana.
2. I have reviewed the report and concur with recommendation 1. An Action plan has been implemented and is identified in the Director Comments. I request the closure of recommendation 1.

(Original signed by:)

Peter Dancy, FACHE
Director/CEO
Alexandria VA Health Care System

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