US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Altoona Healthcare System in Pennsylvania

Healthcare Facility Inspection	25-00206-14	December 3, 2025

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors. 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 Altoona Healthcare System (facility) from March 24 through 27, 2025.[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 the executive order that required employees to return to the office and reduce telework as a system shock.[2] The leaders discussed how they implemented the order and communicated information to employees. Leaders reported they shared information through daily huddles, town halls, visits to work areas, an internal website, and a newsletter.[3]

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[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] "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[3] A huddle is a daily meeting with all team members present to "identify and communicate the resolving [of] patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues." "VHA National Center for Patient Safety, Patient Safety Huddle Board," Department of Veterans Affairs, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.asp.

The OIG found the facility's All Employee Survey scores for communication and information sharing, transparency, best places to work, no fear of reprisal, and psychological safety exceeded VHA's averages from fiscal years 2022 to 2024.[4] Respondents to an OIG questionnaire indicated that leaders had improved their communication; the information was clear, frequent, and useful; and they felt empowered to suggest further improvement.

The facility's patient advocates said veterans could provide feedback to leaders about their care and concerns, and they were responsive.[5] Executive leaders emphasized that their priority is to deliver care to veterans.

Environment of Care

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

The OIG successfully navigated to the facility and entered the site guided by directional signs. The OIG noted signs for accessible parking for those with disabilities. There were multiple security cameras located on each parking lot level and police call boxes at every elevator, identified by a bright blue light. The OIG found the entrance area to be roomy, clean, and adequately lit. The facility was easy to navigate, and had features to aid veterans with sensory impairments find their way around.

Overall, the OIG found patient care areas were clean and well-maintained. However, the OIG found expired fruit juice and medical supplies, and a cardboard box in a clean linen room, which is an infection risk. Staff corrected all findings immediately, so the OIG did not issue a recommendation.

Environment of care leaders identified unfilled staffing positions as a barrier to maintaining a clean and well-functioning facility. Despite this barrier, the OIG found facility staff exceeded VHA targets for staff to complete work orders for identified deficiencies within 14 days and

[4] 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. "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.

[5] 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/.

leaders to participate in environment of care rounds (inspections) more than 90 percent of the time.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined staff complied with VHA requirements and communicated test results to providers and patients, assigned surrogates as needed, and communicated results outside regular clinic hours and during transitions in care. However, the OIG found the facility did not have the required service-level workflows, which describe staff's roles in the communication process, for each service and made a recommendation. The Executive Director responded to the recommendation and provided evidence that leaders updated the facility's policy to include service-level workflows. The OIG now considers this recommendation closed (see OIG Recommendations and VA Responses).

The OIG noted that the facility works with the National Teleradiology Program to report radiology results after hours and noted program staff did not always provide stat (urgent) and routine results in required time frames. To mitigate any delays, facility leaders hired contract providers to review radiology results as needed.

There were no open OIG recommendations for the facility for the past three years.[6] The acting Chief of Staff and quality management staff said leaders and staff identify patient safety concerns and opportunities for continuous improvement through audits, patient safety reports and forums, leadership huddles, and meetings. Staff also provide feedback, education, and lessons learned from external reviews, such as OIG and Joint Commission inspections, and internal quality reviews, like root cause analyses to other staff members.[7] Leaders identified processes they use to monitor internal improvement actions until they are completed and for an additional 6 to 12 months to ensure they sustain improvements.

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

[6] VA OIG, *Comprehensive Healthcare Inspection of the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania*, Report No. 23-00092-12, October 26, 2023.

[7] A root cause analysis is "a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[8]

The OIG found the facility had a few vacancies filled by float staff (staff not assigned to regular teams). Although facility leaders said there were vacancies within primary care, they clarified they did not have problems recruiting staff because the facility is a desirable place to work and has a low staff turnover rate.

Staff explained they work well together to ensure they see patients in a timely manner. The OIG found that average primary care appointment wait times for new and established patients were under two weeks.

Primary care and executive leaders recognized staff were overburdened with view alerts.[9] Leaders said primary care providers enter many consults so patients can receive specialty or community care, which results in a high volume of alerts.[10] They added that staff use view alerts to communicate patient information to one another. A task group educated staff on better ways to communicate, and view alerts for primary care providers decreased since February 2024 from an average of 137 to 123 alerts per provider per day. Leaders plan to implement these changes in other services.

Leaders and primary care staff also said community providers did not send documents to the facility in a timely manner, which could delay patient care and result in patient harm. Leaders explained the inefficiencies were due to community providers using different processes to send the documents. The OIG made one recommendation. In response, the Executive Director reported that leaders will review practices to determine if they can implement a standardized approach to improve timeliness in receiving documents from community care providers (see OIG Recommendations and VA Responses).

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans into the programs and how well they meet veterans' needs. The OIG found the facility had programs that help identify homeless veterans and meet their needs with assistance from community partners. The Public Affairs Officer spoke about staff's positive

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

[9] A view alert is a brief interactive electronic notification in a computerized patient record system designed to inform the user about activities. Department of Veterans Affairs Office of Information & Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version*, October 2024.

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

relationship with the media and their monthly segments on a local news station lifestyle show promoting facility services.

However, program staff cited multiple barriers to meeting veterans' needs, including the large, rural, 14-county service area; transportation difficulties; lack of phone and internet accessibility; and limited shelters and one-bedroom apartments. Staff described the recent program reorganization where veterans justice specialists were assigned part-time responsibilities in the Housing and Urban Development–Veterans Affairs Supportive Housing program. Health Care for Homeless Veterans staff said the reorganization enhanced the homeless programs' care coordination and efficiency, and improved access and services for veterans in rural areas.

In addition, the chief and program leaders and staff admitted staff did not document outreach activities and workload accurately in VA's national database system until recently, which resulted in some programs not meeting VHA targets. Staff have since received education on the requirements.

What the OIG Recommended

The OIG made two recommendations.

1. The Executive Director ensures each service has a service-level workflow for test result communication.
2. The Executive Director reviews current practices to obtain documents from community providers and determines if leaders can standardize an approach to improve timeliness.

VA Comments and OIG Response

The acting Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans (see OIG Recommendations and VA Responses and appendixes C and D for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendation, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Altoona Healthcare System
Altoona, Pennsylvania
Level 3-Low Complexity
Blair County
Hospital Referral Region: Altoona

Description of Community

POPULATION

Female **424,750**	Male **437,165**
Veteran Female **4,441**	Veteran Male **54,361**

Homeless - State **12,691**
Homeless Veteran - State **778**

MEDIAN INCOME

$54,025

EDUCATION

90% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **162**

SUBSTANCE USE

25.4% Driving Deaths Involving Alcohol
19.9% Excessive Drinking
270 Drug Overdose Deaths

UNEMPLOYMENT RATE

7% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	301,447
Carpool	35,412
Work at Home	20,041
Walk to Work	16,115
Other Means	5,914
Public Transportation	5,595

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**25.5 Minutes, 21 Miles**
Specialty Care	**60.5 Minutes, 50.5 Miles**
Tertiary Care	**124.5 Minutes, 114.5 Miles**

Access to Health Care

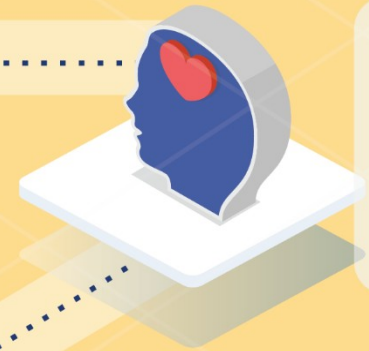
ACCESS

VA Medical Center Telehealth Patients **9,316**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	38%
<65 without Health Insurance	12%

Health of the Veteran Population

1 VETERAN HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

5,687

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.73 Days

30-DAY READMISSION RATE

12%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
18	33

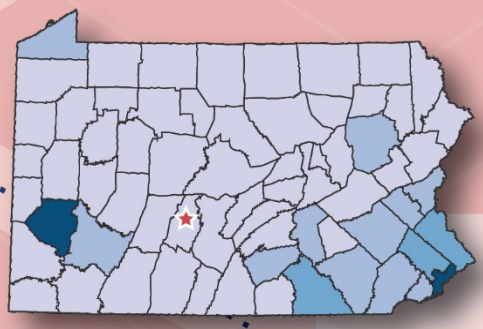
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	27K
Unique Patients VA Care	26K
Unique Patients Non-VA Care	12K

COMMUNITY CARE COSTS

Unique Patient $25,583	Outpatient Visit $323
Line Item $1,244	Bed Day of Care $347



★ VA MEDICAL CENTER

VETERAN POPULATION

0.07% 1.97% 3.86% 5.75% 7.64% 9.52%

STAFF RETENTION

Onboard Employees Stay <1 Yr	14.43%
Facility Total Loss Rate	8.29%
Facility Retire Rate	1.95%
Facility Quit Rate	5.71%
Facility Termination Rate	0.55%

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) 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 (VA), "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]

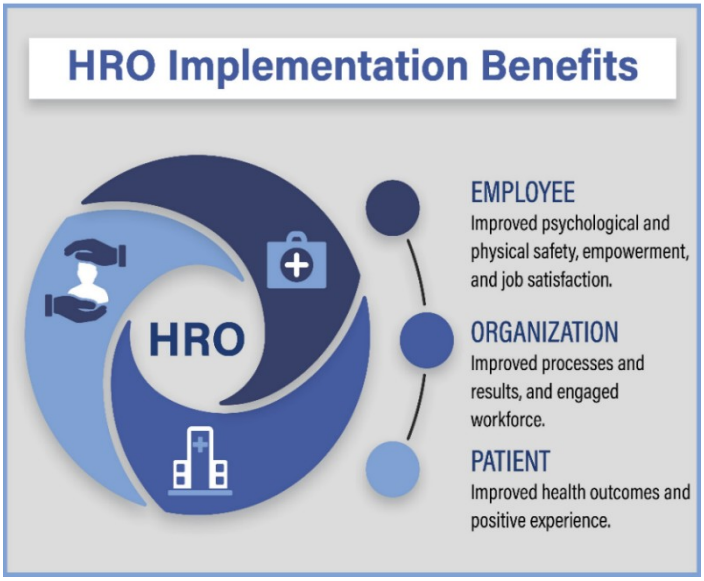


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 inspectors observed how facility leaders incorporated high reliability principles into their operations.

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[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.

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 (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 Altoona Healthcare System (facility) began caring for veterans in 1950. In fiscal year (FY) 2024, the facility served 14 counties in rural central Pennsylvania, operated five community-based outpatient clinics, and provided care to 27,547 veterans.[13] It also had 51 operating beds (11 inpatient and 40 community living center beds), and a budget of $385,074,809.[14]

According to documents provided by staff prior to the March 2025 inspection, the facility's executive leaders consisted of the Executive Director (Director), Associate Director for Operations, Chief of Staff, acting Associate Director for Patient Care Services, and acting Chief of Quality and Patient Safety. The Executive Director, Associate Director for Operations, and Chief of Staff have worked together for 1.5 years.

A 2018 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."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[17]

[13] The community-based outpatient clinics are in DuBois, Huntingdon County, Indiana County, Johnstown, and State College.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_Community_Living_Centers.asp.

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

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

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

System Shocks

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

In an interview, executive leaders identified the executive order that required staff to return to the office and reduce telework as a recent system shock.[20] Leaders said it was a challenge to find space for all staff to work in-person at the facility. To comply with the executive order, leaders evaluated space to determine how they can accommodate staff and planned to coordinate interoffice moves.

Leaders also explained they were recruiting and hiring new staff; however, because of an additional executive order that froze hiring, they were unable to carry out their plans.[21] Leaders said they had increased staffing by 40 percent since 2019 and were now required to reduce staffing to 2020 levels. Leaders reported they cut between 70 to 80 positions by not replacing staff who retired or resigned. Leaders stated they worked with service chiefs and reviewed workload, staffing levels, and patient satisfaction scores to determine which positions are mission critical.

Leaders said they communicate information about the executive orders to staff as they receive it, which they identified as key to managing their concerns. Approximately 800 virtual participants attended question and answer sessions about the executive orders. Leaders also hold town halls in which 400 to 500 staff members attend. They described an internal website they created called Chime In, where staff enter questions, the Director reviews them weekly, and the Director's executive assistant posts the responses for all to see.

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

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

[20] "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[21] "By the authority vested in me as President by the Constitution and the laws of the United States of America, I hereby order a freeze on the hiring of Federal civilian employees, to be applied throughout the executive branch. As part of this freeze, no Federal civilian position that is vacant at noon on January 20, 2025, may be filled, and no new position may be created except as otherwise provided for in this memorandum or other applicable law." Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 20, 2025).

Leadership Communication

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

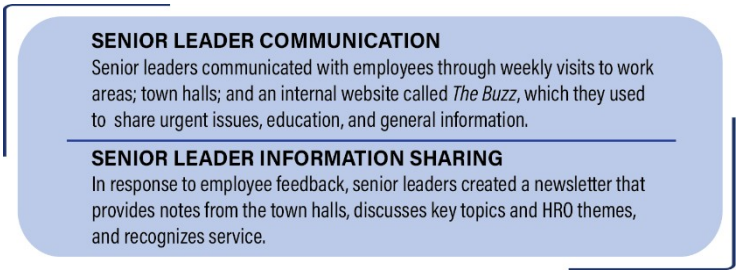

Figure 4. *Leaders' communication with employees. Source: Interview with facility leaders.*

Survey scores for senior leaders' communication, information sharing, and transparency consistently exceeded VHA's averages from FYs 2022 to 2024. Executive leaders said they use survey feedback to improve how they communicate with employees. For example, in response to receiving multiple emails from employees, leaders created a site called *The Buzz* where they shared information with staff. Additionally, the leaders learned through feedback that employees missed receiving emails. This prompted them to create a newsletter that contained information from monthly town halls, HRO updates, and service recognitions. Furthermore, leaders explained they continually use feedback to improve each year and said the facility was among the top five in the country for employee survey participation.

Leaders talked about how they embrace HRO principles and use daily huddles to share information and solve problems.[26] During huddles, team members employ a variety of tools to coordinate their work; communicate; and share staffing, patient care, and process improvement

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

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

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

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

[26] Huddles are a daily meeting with all team members present to "identify and communicate the resolving [of] patient safety issues, deliver timely recognition and resolution of problems, and provide an increased focus on operational safety issues." "VHA National Center for Patient Safety, Patient Safety Huddle Board," Department of Veterans Affairs, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.asp.

projects with one another and facility leaders. Leaders also described how they brief the Director daily; visit work areas weekly, at night and on weekends; and meet quarterly with employees at community-based outpatient clinics to share information. Respondents to the OIG questionnaire largely agreed that leaders had changed how they communicate information; the changes were an improvement; and the information was clear, frequent, and useful.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28]

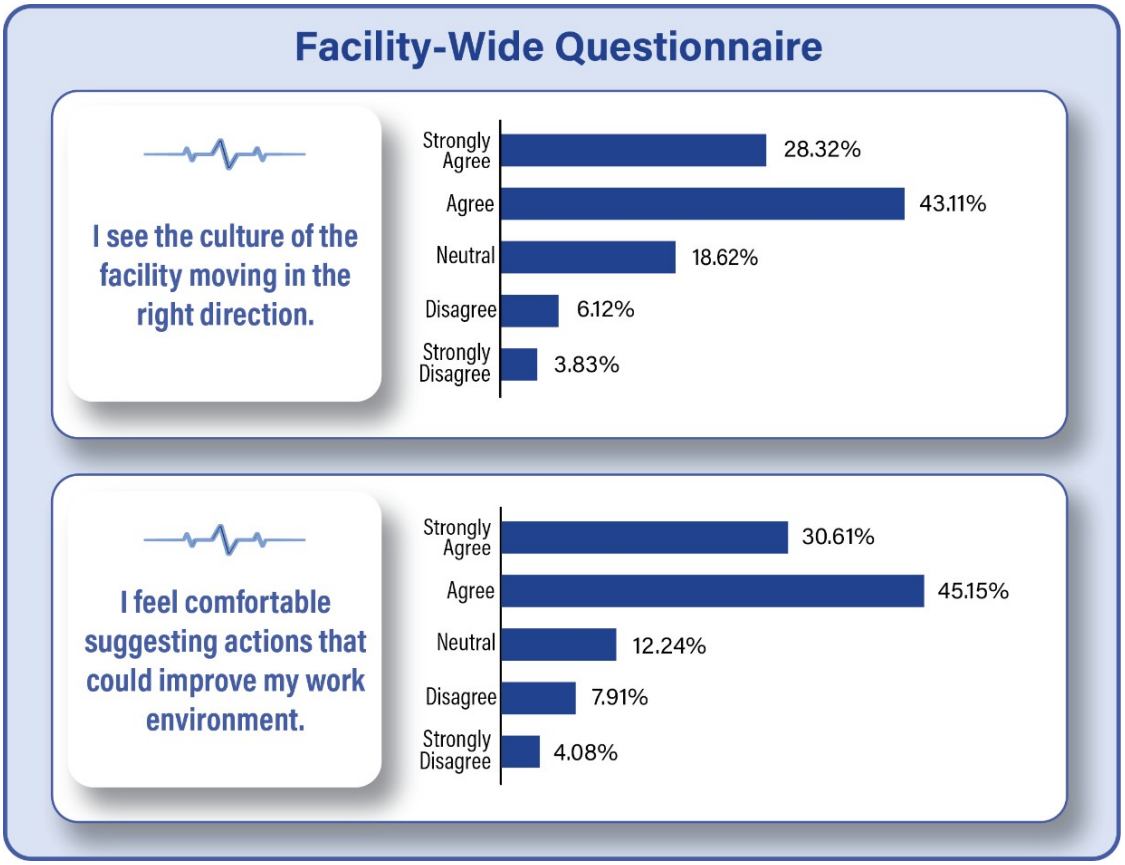

Figure 5. *Employees' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

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

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

The 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 OIG found survey scores for best places to work, no fear of reprisal, and psychological safety exceeded VHA's averages from FYs 2022 to 2024. Executive leaders attributed the improvement to their visibility to employees during visits to various areas throughout the organization. In addition, the Director said that due to the executive leadership team's open style of communication, employees feel comfortable approaching them, and know they will listen to and act on their concerns.

Most respondents to the OIG questionnaire indicated VA's mission, job satisfaction, and pay and benefits kept them at the facility, and they had not considered leaving. Leaders stated to help improve the facility's culture, they invested in employees' experiences by expanding work schedule options and implemented employee recognition programs, such as the DAISY, I CARE, and BEE Awards.[29]

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[30] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

The patient advocates indicated that veterans can provide direct feedback to facility leaders, and they are responsive to veterans' concerns. Executive leaders reported the patient advocates track all complaints until they are resolved.

Leaders said they prioritize providing care to veterans. Leaders also said veterans recently voiced concerns about how some of the executive orders may affect their health care and benefits. In response, they encouraged providers to reinforce with veterans that they are, and will continue to be, cared for and supported at the facility. The Director also reported meeting monthly with five

[29] The DAISY Award recognizes "those nurses who make a big difference in the lives of so many people." "The DAISY Award," Department of Veterans Affairs, accessed May 8, 2025, https://www.va.gov/daisy-award. VA's Core Values "are Integrity, Commitment, Advocacy, Respect, and Excellence—better known as 'I CARE.'" "I CARE," Department of Veterans Affairs, accessed May 8, 2025, https://department.va.gov/icare. "The BEE (Being Exceptional Everyday) award is a VA-sponsored program that recognizes and celebrates Nursing Service support staff who demonstrates excellence through their clinical skills and the extraordinary compassionate care they deliver everyday." "Bee Award," Department of Veterans Affairs, accessed May 8, 2025, https://www.va.gov/bee-award.

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

veterans service organizations to keep them informed of any changes at the facility or within VA, and to listen to their concerns and opinions about care and services.[31]

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: "VA Altoona Health Care," Department of Veterans Affairs, accessed September 3, 2025, https://www.va.gov/altoona-health-care/.

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]

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[31] 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.

[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.

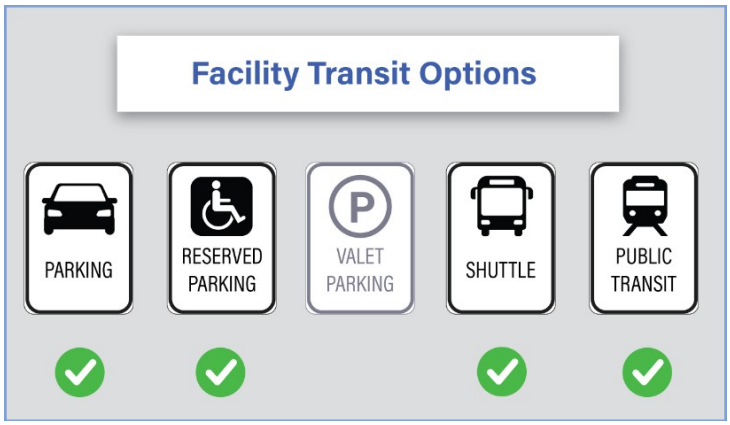

Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG entered the facility's address into a navigation system that successfully guided them to the main entrance. A public bus stop is a short walk across the street. According to responses from an OIG questionnaire, the facility provides or coordinates transportation from a variety of options, including shuttle service to a larger nearby VA medical center for additional services, and van service to and from veterans' homes.

Road signs direct veterans to the parking lots and garage, which are side by side. In the garage, directional signs guide the traffic, and others designate accessible parking for veterans with limited mobility. The garage and parking lots are well lit, and facility police monitor security cameras that are located on every level. The parking garage also has police call boxes, identified by a bright blue light, at every elevator.

Main Entrance

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

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

The OIG found the main entrance to be spacious, clean, and bright, with a mix of fluorescent lights and natural lighting from large windows along the corridors. The OIG also observed a clean lobby, with an information desk staffed with greeters and escorts who bring patients to their destinations. There is also a vendor in the lobby that sells coffee, snacks, and sandwiches, with an adjacent seating area.

[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*.

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]

The OIG found color maps of the facility on its public website, and clinic and office maps posted on walls to help veterans successfully navigate the facility.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] An OIG questionnaire respondent indicated staff provide assistive devices and arrange sign language services for sensory impaired veterans to help them navigate the facility. For visually impaired veterans, the OIG observed braille on wall signs outside exam rooms and offices, as well as on elevator panels, and elevators with audible tones when doors open and close at each floor.

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.[38] A toxic exposure screening navigator revealed the facility has two navigators. The OIG found toxic exposure handouts at the information desk and in patient education displays. Executive leaders stated they assembled a team of social workers, nurses, and

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

[37] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "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.

[38] 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.

providers to develop and execute a plan to educate veterans about toxic exposure; and public affairs staff promoted the screenings on social media.

Primary care staff explained that when a veteran arrives for an appointment, nursing staff now complete the first part of the toxic exposure screening. If the veteran identifies an exposure to a toxic substance, the nurse notifies a provider, who then completes the secondary screening and addresses any questions or concerns the veteran may have. Executive leaders reported staff had screened 93 percent of veterans enrolled at the facility.

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.[39]

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.

In an interview, environment of care leaders stated staffing is the biggest barrier they face in correcting environment of care-related problems because they are unable to fill positions. Despite this barrier, the OIG found staff exceeded VHA's targets to correct work orders (resolve deficiencies) within 14 days, and for leaders to attend environment of care rounds (inspections) 90 percent of the time. The OIG did not identify any repeat findings.

General Inspection

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

The OIG observed clean exam and patient rooms, furnishings in good condition, and equipment with current safety inspections. Additionally, the OIG found the community living center to be a home-like environment, where staff maintained residents' privacy and residents' food was easily distinguishable from facility-provided food. However, the OIG found expired fruit juice and medical supplies, and a cardboard box in a clean linen room, which is an infection risk. Staff immediately corrected these problems; therefore, the OIG did not issue a recommendation.

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

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[40] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[41]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The facility had local processes and policies to communicate abnormal test results to ordering providers and patients, assign a surrogate when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours and when providers transition a patient's care from one setting to another.

However, the OIG found that only radiology, laboratory, cardiology, and community care services had workflows that described staff members' roles in the communication process.[42] VHA requires facilities to have workflows for each service to communicate results to providers who order tests and to patients.[43] Facility leaders said they use the local policy as the workflow for all other services. The OIG recommended the Executive Director ensures each service has a service-level workflow for test result communication. In response to the recommendation, the Executive Director reported leaders updated the facility's policy to include service-level workflows, and the OIG considers this recommendation closed (see OIG Recommendations and VA Responses).

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

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

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

[43] VHA Directive 1088(1).

VHA further requires facilities to have a process for monitoring test result communications to providers and patients.[44] During an interview, the acting Chief of Staff and quality management staff said the External Peer Review Program Coordinator regularly monitors abnormal test results that require follow-up and discusses the results and possible trends with facility leaders.[45] Overall, the OIG found facility leaders had consistent processes to effectively monitor and address any identified deficiencies with test result communications.

Those interviewed also reported the facility uses the National Teleradiology Program to interpret results of after-hours radiology diagnostic exams.[46] The Chief of Radiology said staff consistently meet timeliness requirements for critical results, but not for stat (urgent) or routine results.[47] The Chief of Radiology said staffing shortages delayed radiologists in interpreting results. Therefore, leaders hired four contracted radiologists to interpret stat and routine results as needed. Staff reported that facility leaders monitor whether radiologists interpret diagnostic exams in a timely manner through a quality assurance surveillance plan and noted that no adverse events had occurred related to the delays.

Action Plan Implementation and Sustainability

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

[44] VHA Directive 1088(1).

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

[46] The VHA National Teleradiology Program "provides 24/7 diagnostic radiology services to Department of Veterans Affairs (VA) medical facilities located in all Veterans Integrated Service Networks (VISNs), rendering final diagnostic interpretations on a wide variety of modalities including computerized tomography scans (CTs), X-rays, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine imaging studies." VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020. Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed February 13, 2025, https://www.va.gov/visns.

[47] Critical results should be available and reported to the ordering provider or designee within 60 minutes. Altoona VA Medical Center, MCP [Medical Center Policy] 11.18, "Communicating Test Results to Practitioners and Patients," February 11, 2025. According to facility leaders, teleradiology program staff should provide stat results in one hour or less and routine results in 48 hours.

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

The OIG found no open recommendations for improvement from previous OIG reports for the past three years.[49] The acting Chief of Staff and quality management staff said they routinely work with service leaders to track action plans to address the recommendations. Staff then report on their status and results to several governing bodies until completed. Quality management staff said they discuss repeat findings with executive leaders, and work collaboratively with service leaders and staff to monitor the actions for 6 to 12 months to ensure they 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.[50] 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.[51] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

During an interview, the acting Chief of Staff and quality management staff said facility leaders and staff identify patient safety concerns and opportunities for improvement through audits, patient safety forums, reports in VHA's Joint Patient Safety Reporting system, leadership huddles, and meetings.[52] Leaders also enlist staff to provide feedback and share lessons learned from external reviews, such as OIG and Joint Commission inspections, and internal reviews, like root cause analyses; and explain changes to policies and processes to other staff members.[53]

In addition, executive leaders said staff track issues through an interactive form referred to as STEPS (safety, team, equipment, process, and supply). Staff in each service use this form daily to report issues in their area and give accolades to colleagues. Executive leaders then resolve the issues and communicate the outcomes to the staff members. Interview participants did not identify any barriers to staff initiating process improvement projects, and said staff used to submit most patient safety reports anonymously but currently sign them, which indicates they do not fear reprisal.

The Patient Safety Manager described a successful change in a process that VHA later recognized as a best practice. VHA requires staff to complete Joint Patient Safety Reporting system patient safety event investigations in a timely manner, and considers the investigations

[49] VA OIG, *Comprehensive Healthcare Inspection of the James E. Van Zandt VA Medical Center in Altoona, Pennsylvania*, Report No. 23-00092-12, October 26, 2023.

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

[51] VHA Directive 1050.01(1).

[52] 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.

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

overdue if not closed within 14 days.[54] The manager discussed this with the Director, who requested that staff complete the investigations within 7 days. Subsequently, the manager shared the Director's request and trained investigators to complete the investigations within 7 days instead of 14, and the Patient Safety Manager said they decreased completion time. The Patient Safety Manager reported that in May 2024, VHA's National Center for Patient Safety Symposium panel identified this change as a best practice.[55]

Quality management staff said they meet daily with executive leaders to discuss safety concerns and determine if staff need to review them further. For example, the Patient Safety Manager notified executive leaders of an instance where staff did not communicate pathology test results to a patient. After further investigation, leaders and staff determined several patients experienced delays in receiving their results. In response, leaders trained staff to communicate test results as required and hired another provider to review all pathology reports.[56] Quality management staff continue to monitor these results to ensure staff communicate them within the required time frame. The Patient Safety Manager said quality management staff may perform an aggregate review of abnormal and critical test results to ensure staff communicate them.[57]

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[58] 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.

[54] VHA National Center for Patient Safety, *JPSR Guidebook*.

[55] The VHA National Center for Patient Safety "promotes best practices for safe patient care and optimal patient care utilization throughout the organization." The purpose of the VHA National Center for Patient Safety Symposium is to provide a forum for healthcare professionals "to share best practices, emerging research, available resources, opportunities for collaboration, leader perspectives, and professional opportunities" to improve patient safety improvement for all populations. "VHA National Center for Patient Safety, NCPS National Patient Safety Symposium," Department of Veterans Affairs, accessed April 6, 2025, https://www.patientsafety.va.gov/ncps.asp.

[56] The provider identified that staff notified three patients of their pathology results and determined there were no adverse outcomes.

[57] An aggregate review is "a is a method to analyze a collection of similar patient safety events (usually in a high-volume category such as medication and fall events) to determine prominent themes and risks worthy of a formal focused review." VHA Directive 1050.01(1).

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

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.[59] 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.[60] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG reviewed a list of primary care vacancies and noted four provider, one registered nurse, and three medical support associate vacancies across 26 primary care teams. Executive and primary care leaders said they increased primary care staffing over the past few years, which included float staff who are not part of regular teams. The leaders said a few providers had recently retired or left the facility, and they filled those vacancies with float providers. The leaders elaborated they have no issues recruiting staff because the facility is a desirable place to work and has a low turnover rate.

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.[61] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[62] One primary care team member reported that leaders assigned additional patients to the team because a provider left. Staff said patients did not experience delays in care because they work together to identify higher priority patients and fit them into the schedule as needed. The OIG determined the average wait time for primary care appointments for new and established patients in FY 2024 was less than two weeks.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[63] 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. Primary care staff said that if they have any general concerns or want to undertake process improvement projects, they discuss it with their direct supervisors.

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[59] 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).

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

[61] "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).

[62] VHA Directive 1406(2).

[63] VHA Handbook 1101.10(2).

During interviews, executive and primary care leaders and staff identified alert fatigue as a challenge for primary care staff and facility providers. They receive a high volume of view alerts in the electronic health record system due to the number of consults they enter for specialty and community care.[64] Staff explained that view alerts notify providers about actions taken on a consult, including test results, scheduled appointments, and telephone interactions. Primary care staff reported they felt overwhelmed by the number of view alerts they receive each day; one provider reported getting about 1,000 alerts per week.

Although leaders said there was no negative impact on patient care, facility leaders explained they commissioned a Primary Care Alert Reduction Task Group to eliminate or reduce unnecessary view alerts and improve communication. The task group educated staff to only add a comment to the consult when the facility provider needs to take action, and address patient concerns during huddles to prevent unnecessary alerts. Through these efforts, the task group decreased alerts by 10.2 percent since February 2024, reducing the average number of alerts per provider from 137 to 123 per day. Facility leaders plan to expand these changes to other services at the facility.

Leaders and primary care staff also said community providers did not send patients' medical documents to facility providers in a timely manner. In one example, a community provider did not send documents for three to four months following the patient's appointment, and within the documents was a request for the facility provider to order additional tests. Because there was a delay in the community provider sending the documents, the patient was delayed receiving additional care. Leaders acknowledged the inefficiencies in getting documents from community providers and said it is because there is not a direct or streamlined approach for community providers to send them. The OIG recommended the Executive Director reviews current practices to obtain documents from community providers and determines if leaders can standardize an approach to improve timeliness. In response, the Executive Director indicated leaders will evaluate current practices to determine if they can implement a standardized process (see OIG Recommendations and VA Responses).

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. Veteran enrollment was stable

[64] A view alert is a brief interactive electronic notification in a computerized patient record system designed to inform the user about activities. Department of Veterans Affairs, Office of Information & Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version*, October 2024. Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

from FY 2022 through July 2024. Leaders and primary care staff noted the PACT Act did not delay care.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice 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.

The Chief of Mental Health discussed a facility-wide focus on productivity in 2024. Program staff said this resulted in facility leaders' reorganization of the HCHV, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice programs approximately six months prior to the OIG's inspection in March 2025. Staff explained that prior to the reorganization, staff from each program reported to the Chief of Social Work, but that position had been vacant since December 2024, and there were no plans to fill it. Therefore, staff now report directly to the Chief of Mental Health.

After the reorganization, the Chief of Mental Health and HCHV program leaders and staff described issues with documenting HCHV outreach activities and Veterans Justice Program admissions, discharges, and transfers in VA's national database tracking system, which captures the programs' workload. The chief could not explain why staff did not use the database, but indicated they have since been trained and use it.

The chief stated that because Veterans Justice Program staff did not track their workload properly, facility leaders believed the program had too many staff. The chief clarified the Housing and Urban Development–Veterans Affairs Supportive Housing program had only one full-time staff member during that time, and many positions remained vacant for long periods due to a lack of applicants. Therefore, executive and program leaders reassigned some of the Veterans Justice Program staff to work part-time in the Housing and Urban Development–Veterans Affairs Supportive Housing program.[65]

HCHV staff said the reorganization improved program care coordination and efficiency. For example, staff from all three programs meet regularly to coordinate services, which ultimately improved access and services for veterans in rural areas. The chief said the HCHV Program

[65] "VJP [Veterans Justice Program] Specialists and Peer Specialist staff in centrally funded positions are not assigned collateral duties that interfere with their ability to perform their VJP duties." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024. Although the VHA directive states they cannot be assigned collateral (additional) duties, the VHA Homeless Programs Office program staff approved a position modification with an updated functional statement that described new responsibilities for the Veterans Justice Outreach program staff, which included working part-time in the Housing and Urban Development–Veterans Affairs Supportive Housing program.

Coordinator is now responsible for all three programs, as well as for providing case management services for several veterans participating in the Housing and Urban Development–Veterans Affairs Supportive Housing Program.

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.[66]

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).[67] 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."[68]

The program did not meet the HCHV5 target in FY 2024. Program staff said it was difficult for them to identify homeless veterans because of the 14-county rural service area and lack of homeless encampments (outdoor areas where homeless people live in a temporary shelter). Staff explained they rely on community partners within their service area to help them find and identify homeless veterans. For example, staff said they recently learned that veterans congregate at the local railyard, so they asked railyard staff to contact them when they encounter a homeless veteran.

> The Public Affairs Officer reported a good relationship with the media and detailed the facility's monthly segments on a local news station lifestyle show. The intent is to make the community aware of the facility's presence and activities. The officer also noted the media posts facility activities on their social media pages.

Figure 10. *Local media involvement in promoting veteran services.*
Source: OIG interview with HCHV program staff.

Once staff identify a veteran, they often face additional enrollment barriers, such as lack of temporary housing, transportation challenges, and communication issues. Program staff said the 10 shelters in their service area, including 1 family shelter, are usually fully occupied. If a shelter

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

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

[68] 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.

is full, they rely on community partners to get the veteran a hotel voucher until transitional or permanent housing or a shelter becomes available. Additionally, they said given the long distances between the rural counties and the facility, it can require an entire workday to transport or meet with a veteran. Staff also described communication challenges, and gave the example that many homeless veterans do not have a cell phone or they stay in hotels without land-line telephones, so staff cannot easily contact them.

Staff reported they joined multiple point-in-time counts in FYs 2024 and 2025, and said it was useful to participate because of the networking opportunities with community partners and volunteers. Program staff described their outreach activities in FY 2025 with county shelters, local housing and service providers, community centers, and community behavioral health programs, and said they compiled a list of county shelters and providers that offer services to veterans.

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).[69] The HCHV Program Coordinator explained VHA has exempted them from the HCHV1 and HCHV2 performance measures since January 2023 due to the facility's lack of contracted shelter beds (contracted temporary housing).[70]

Recently, the facility and other VA facilities in the Pennsylvania area signed a memorandum of understanding with PAServes, a community-based referral system in western Pennsylvania. PAServes provides a wide range of assistance to service members, veterans, and their families, such as housing, emergency services, employment, recreation, fitness, and financial support.

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

[69] 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*.

[70] Facilities may contract with community agencies to provide temporary veteran housing. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

illness, physical health diagnoses, and substance use disorders."[71] 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.[72]

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).[73] The program did not meet the targets for FYs 2022 through 2024.

The HCHV Program Coordinator attributed not meeting the measure to the facility's rural location and associated low patient volume. The coordinator reported the program had 107 housing vouchers, with 16 available across the service area. Staff said they use vouchers to house veterans as quickly as possible, but it may take several months because of their rural location.

Program staff said finding one-bedroom apartments or housing in some areas was a challenge, and there are more two- or three-bedroom apartments available. Staff also mentioned Pennsylvania State University is nearby, so the program competes for housing with students who want to live in the area. As a result, staff work with multiple community and VA programs to obtain temporary housing when veterans require it.

Program staff reported multiple barriers that prevent veterans from enrolling in the program, including lack of phones and internet access, difficulty using technology, mental health challenges, limited transportation, and missing documents like Social Security cards.

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).[74] The program did not meet the target for FYs 2022 through 2024. Program staff said the compensated work therapy program closed in FY 2022, which affected veterans' employment

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

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

[73] 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*.

[74] 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*.

opportunities.[75] The program reopened in FY 2023 with the hiring of a new coordinator. Staff said they work together to solve problems and identified their team cohesiveness as a strength. For example, a staff member with specific subject matter expertise may help a colleague with a veteran who needs assistance in that area.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[76] 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.[77]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[78] The program did not meet the target for FY 2024. In an interview, veterans justice specialists attributed not meeting the target to dividing their time between working part-time in the program and part-time in the Housing and Urban Development–Veterans Affairs Supportive Housing program, as well as significant drive times to meet with veterans in rural locations. According to the specialists, they have caseloads of approximately 25 veterans in the Veterans Justice Program and 14 in the Housing and Urban Development–Veterans Affairs Supportive Housing Program.

The specialists also explained they actively participate in two regional veterans treatment courts that cover multiple counties.[79] Staff said the courts are successful because they allow veterans to participate in treatment instead of being incarcerated. Additionally, they use video conferencing for hearings, which lets staff attend remotely and saves travel time.

Staff shared they conduct community outreach with local police stations, emergency response services, and legal clinics to educate individuals about the program. For example, staff supplied

[75] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services." "Compensated Work Therapy," Department of Veterans Affairs, accessed April 11, 2025, https://www.va.gov/health/cwt.

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

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

[78] 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*.

[79] A veterans treatment court is a "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.

documents for crisis intervention team trainings they gave to first responders and a criminal advisory board in 2025.

Meeting Veteran Needs

Program staff explained they work with veterans who are involved in or at risk of becoming involved in the criminal justice system. They conduct psychosocial assessments and coordinate treatment based on court requirements and veteran needs. If requested by the veteran, staff may provide their opinion to the probation office or attorneys about whether a veteran should be granted probation. Staff said a strength of the program is their ability to help veterans access services and watch veterans' growth.

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 recommendations on issues related to providers communicating test results and obtaining medical documents from community care providers. Leaders completed corrective actions for one recommendation, which the OIG closed (see OIG Recommendations and VA Responses). Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

OIG Recommendations and VA Responses

Recommendation 1

The Executive Director ensures each service has a service-level workflow for test result communication.

_X_ Concur

____ Nonconcur

Target date for completion: Completed.

Director Comments

Leadership at the James E. Van Zandt VA Medical Center reviewed current Medical Center Policy (MCP) 11.18 Communicating Test Results to Practitioners and Patients which identified workflow processes in place for reporting services (i.e. lab, radiology, respiratory, cardiology and results received through community care) and ordering practitioners. MCP 11.18 was republished May 5, 2025 clarifying separation of these service-specific workflows utilizing appendices to the MCP.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

The Executive Director reviews current practices to obtain documents from community providers and determines if leaders can standardize an approach to improve timeliness.

_X_ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The Executive Director at the James E. Van Zandt VA Medical Center, through the Associate Director, Patient Care Services and Chief, Community Care, will conduct a review of current practices for obtaining documents from community providers to determine if the medical center can standardize an approach to improvement timeliness.

OIG Comments

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

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.[80] 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. 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.*[81]

Potential limitations include self-selection bias and response bias of respondents.[82] 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 March 24 through 27, 2025. 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.[83] The OIG reviews available evidence within a specified

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

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

[82] 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.

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Acting Director, VISN 4: VA Healthcare (10N4)

Subj: Healthcare Facility Inspection of the VA Altoona Healthcare System in Pennsylvania

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

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

I have reviewed the VA OIG Report: Healthcare Facility Inspection of the VA Altoona Healthcare System in Pennsylvania. I am in concurrence with the draft report and facility responses provided.

(Original signed by:)

Denise Boehm
Acting Network Director, VISN 4

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 16, 2025

From: Director, VA Altoona Healthcare System (503)

Subj: Healthcare Facility Inspection of the VA Altoona Healthcare System in Pennsylvania

To: Director, VISN 4: VA Healthcare (10N4)

1. I have reviewed the draft report of the Office of Inspector General (OIG) Healthcare Facility Inspection that was conducted at the Altoona VA Medical Center. I concur with the OIG's recommendations outlined in this draft report.
2. I am submitting corrective action plans for the recommendations.
3. I appreciate the insights and guidance provided by OIG as a collaborative partner in assisting our facility to improve our processes as we strive to deliver high quality care for our Veterans.

(Original signed by:)

Derek Coughenour, PT, DPT, MPM, CLD, VHA-CM
Executive Director

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