US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Northeast Ohio Healthcare System in Cleveland

Healthcare Facility Inspection	24-00590-268	October 16, 2024

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

OUR MISSION

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

CONNECT WITH US

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

PRIVACY NOTICE

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

Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established a cyclical review program called Healthcare Facility Inspection. 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 Northeast Ohio Healthcare System during the week of March 18, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed. The OIG made no recommendations for improvement.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. Executive leaders identified the COVID-19 pandemic as a recent system shock that affected the facility. Leaders responded by activating the facility command center and co-locating subject matter experts inside the command center to manage the situation. Leaders reported working closely with community partners to ensure availability of resources and management of patient care. Leaders acknowledged the importance of being transparent with communication to staff and patients and being visible throughout the facility.

The OIG found that facility leaders were open and receptive to thoughts and ideas from staff and had a history of fostering innovation for over 20 years. Staff routinely submitted 30 to 40 innovative ideas annually. One example is the Medical Modeling 3-D Printing Program. Staff print medical models for complex surgical procedures and use them to educate physician residents and patients about the disease and upcoming surgery. Initially, a staff member thought

[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.

of printing medical models, and leaders approved the project as an ancillary duty. The staff member now leads a team that provides medical models to over 30 VA medical centers.[2]

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 physically inspected patient care areas, focusing on safety, cleanliness, infection prevention, and privacy. The OIG also 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. The OIG inspected several clinical and nonclinical areas and found the facility to be clean and well-maintained. The facility had ample parking, a welcoming main entrance, and was easily navigable with the use of maps and wayfinding. The facility had a kiosk that provided personalized directions that could be printed or used through a mobile application.

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 findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found leaders regularly audited data related to provider notification of test results and addressed problems as they arose. Through an interview, the OIG learned that quality management staff monitored sustainment of corrective actions, and leaders supported process improvement projects. The OIG did not identify any barriers to long-term improvements related to general patient safety.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[3] Although facility staff reported a shortage of administrative associates, the OIG found patients did not experience increased appointment wait times or delays in care. In anticipation of an increase in patient population during the COVID-19 pandemic, facility leaders hired additional primary care staff to meet the anticipated demand. However, the facility experienced a decrease in veteran enrollment, which leaders

[2] Additional photos related to the Medical Modeling 3-D Printing Program are found in appendix C.

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

attributed to slow population growth in the area and veterans either relocating to warmer climates or receiving care elsewhere. To try to increase veteran enrollment, leaders conducted outreach events and used social media to advertise services offered at the facility.

Primary care staff discussed feeling supported by facility leaders and noted a collaborative relationship to develop process improvement projects. One such project was the initiation of the nurse triage clinics for walk-in patients. Primary care staff also reported the implementation of the PACT Act did not affect wait times.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identified and enrolled veterans and assessed how well the programs met veterans' needs. The OIG found the facility had active homeless and veterans justice programs with a strong emphasis on outreach services and connections with multiple community partners. The facility introduced a Mobile Medical Unit that allows for the expansion of medical care and clinical services to homeless and at-risk veterans across the facility's service area. Homeless program staff identified a need to work closely with aging veterans who may be experiencing homelessness for the first time and developing housing options for them. Although the facility was not meeting some of the homeless program's metrics, the OIG did not make recommendations because program staff are working within their resources to address the needs of the veterans.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the report (see appendixes D and E, pages 34–35 for the full text of the directors' comments). No further action is required.

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Abbreviations

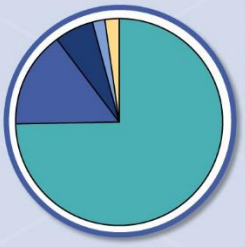
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

VA Northeast Ohio Healthcare System
Cleveland, Ohio
Level 1a-High Complexity Facility
Cuyahoga County
Hospital Referral Region: Cleveland

Description of Community

RACE AND ETHNICITY



MEDIAN INCOME

$60,585

EDUCATION

91% Completed High School
65% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **164**

POPULATION

Female **1,797,224**
Male **1,700,838**
Veteran Female **20,110**
Veteran Male **192,057**

Homeless - State **10,654**
Homeless Veteran -State **633**

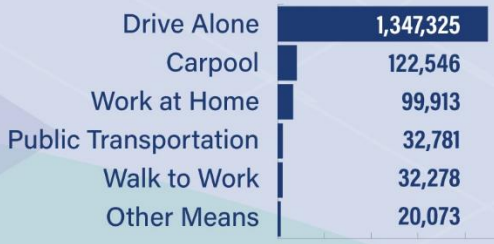
UNEMPLOYMENT RATE

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

SUBSTANCE USE

34.3% Driving Deaths Involving Alcohol
19.2% Excessive Drinking
1,448 Drug Overdose Deaths

TRANSPORTATION



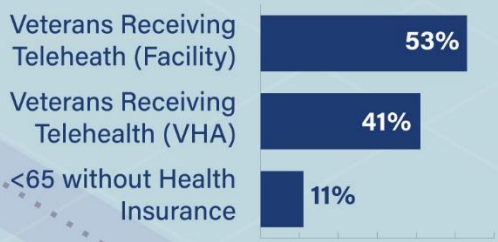
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**15 Minutes, 10.5 Miles**
Specialty Care	**56.5 Minutes, 53.5 Miles**
Tertiary Care	**60.5 Minutes, 59 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **62,734**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

34,416

357 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.29 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

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

Health of the Facility

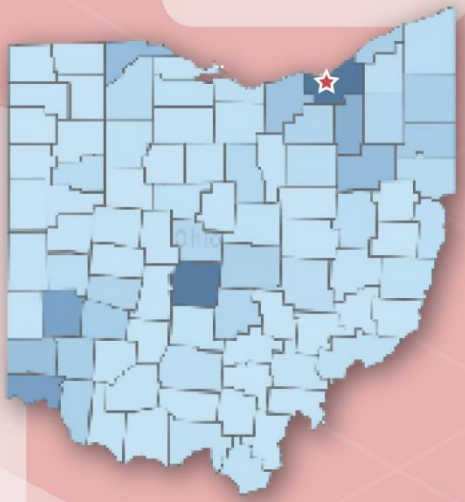
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	141K
Unique Patients VA Care	138K
Unique Patients Non-VA Care	31K

★ VA MEDICAL CENTER

VETERAN POPULATION

809 — 67,325



COMMUNITY CARE COSTS

Unique Patient $39,960	Outpatient Visit $319
Line Item $2,151	Bed Day of Care $339

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.18%
Facility Total Loss Rate	9.98%
Facility Retire Rate	2.21%
Facility Quit Rate	6.69%
Facility Termination Rate	0.91%

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

Contents

Background and Vision

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

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

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

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide

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

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.

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

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

[3] Stephanie Veazie, Kim Peterson, and Donald 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 April 2023.

[6] "VHA's 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.

time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9]

The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

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

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022); The White House, "FACT SHEET: President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans," press release, August 10, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/.

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

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA, accessed May 1, 2023, https://www.accesstocare.va.gov/VA_PACTActDashboard.pdf.

Content Domains

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report, https://www.va.gov/HOMELESS/VA-Homeless-2022-HPO-Annual-Report-508c.pdf.

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.

A leader reported that the VA Northeast Ohio Healthcare System (facility) in Cleveland began caring for veterans in 1964. At the time of the inspection, the facility's executive leaders consisted of an Executive Director, Acting Chief of Staff, Associate Director for Patient Care Services, Deputy Director, Associate Director, and three Assistant Directors.[13] One of the Assistant Directors was the newest member of the executive leadership team, and the Deputy Director had the longest tenure. In fiscal year (FY) 2023, the medical care budget was $1,555,708,923, and the facility provided care to 139,642 veterans.[14] The facility had 617 operating beds, including 296 hospital beds, 122 domiciliary beds, 174 community living center beds, and 25 compensated work therapy/transitional residence beds.[15]

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

[13] At the time of the inspection, the Chief of Staff was detailed to the Veterans Integrated Service Network (VISN).

[14] The medical center is in Cleveland, Ohio, and has 15 community-based outpatient clinics located in Akron; Canton; Cleveland (2); East Liverpool; Lake County; Lorain; Mansfield; New Philadelphia; Parma; Ravenna; Sandusky; Summit County; Warren; and Youngstown, Ohio.

[15] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed August 13, 2024, https://www.va.gov/Geriatrics/CLCs.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 10, 2024, https://www.va.gov/homeless/dchv.asp.

[16] 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.

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

survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[18]

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.[19] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[20] 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 COVID-19 pandemic as being the facility's recent system shock. Leaders discussed the devastation caused by the pandemic and said it took about two years for the facility to return to its current state of operations. They described activating the facility's incident command center at the start of the pandemic and co-locating subject matter experts, such as frontline physicians and infectious disease, supply chain, and environmental management staff, inside the command center to manage the situation.

Leaders also worked collaboratively with local hospitals and clinics to coordinate care and resources. For example, leaders worked with community hospital staff to transfer veterans to the facility for care, so facility and community hospitals could care for their respective patients. Leaders said they believed the key to managing staff during the pandemic was being transparent and open with communication, such as sending emails about the pandemic and facility status to staff twice a day, as well as being present and available. Facility leaders said they increased both direct and indirect patient communications, like calling or using social media to convey pandemic-related information and any changes in the availability of services or functioning at the facility. The OIG made no recommendations.

[18] 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.

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

[20] Valerie M. 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*.

Leadership Communication

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

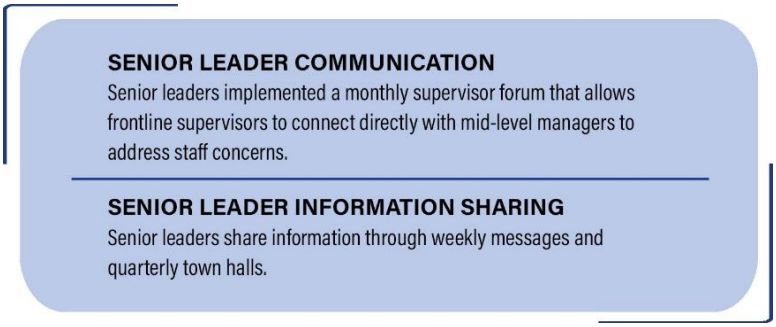


Figure 4. *Leader communication with staff.*
Source: Interviews with facility leaders.

The facility's All Employee Survey scores for communication, information sharing, and transparency improved from FYs 2021 to 2023. In an interview, executive leaders credited continuous improvement to using the survey responses to guide changes in how, when, and what types of methods they used to communicate with staff. Leaders discussed sending weekly messages that included information on HRO efforts, equity and inclusion, current projects, and recent issues. Several leaders reported conducting quarterly town halls and said staff have access to two safety hotlines, one for patient safety concerns and one for staff-related concerns.

Leaders identified two barriers to improving communication, including the number of staff and their work locations and the use of telework. To address these barriers, leaders stated they visited all areas of the facility twice a year and noted the importance of face-to-face interactions with staff. Leaders added they used virtual visits to connect with telework employees. Responses to the OIG's questionnaire revealed that most staff were neutral or agreed that facility leaders made

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

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

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

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

changes to communication, the changes were an improvement, and the communicated information was clear and frequent. The OIG made no recommendations.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[25] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[26] Organizations with cultures that celebrate diversity and inclusion encourage self-expression and enhance psychological safety, part of the safety culture, which is foundational to an HRO.[27] Having workplace staff representative of the veterans and surrounding community can build trust, facilitate communication, and strengthen the relationship between the facility and veterans served.[28] The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity.

Figure 5. *Facility workforce diversity.*
Source: OIG analysis of facility human resources data.

The OIG reviewed employment data and found the facility did not meet the VA target for employing veterans but did meet the target for employing those with disabilities (see figure 5). In response to the OIG-administered questionnaire, the diversity lead reported an advisory board recently completed a survey and provided the results and suggestions on ways to increase diversity to the facility director.

[25] The definition clarifies "unique" as "including but not limited to race, color, national origin, ethnicity, sex, sexual orientation, gender identity, religion, disability status, age and mutable characteristics such as educational background, socioeconomic status, organizational level, geographic region and cognitive/intellectual perspective." VA Directive 5975, *Diversity and Inclusion*, April 29, 2021.

[26] L.E. Gomez and Patrick Bernet, "Diversity Improves Performance and Outcomes," *Journal of the National Medical Association* 111, no. 4 (August 2019): 383–392, https://doi.org/10.1016/j.jnma.2019.01.006.

[27] Psychological safety is the perceived ability to express one's thoughts and opinions without fear of negative repercussions. Barjinder Singh, Doan Winkel, and T.T. Selvarajan, "Managing Diversity at Work: Does Psychological Safety Hold the Key to Racial Differences in Employee Performance?" *Journal of Occupational and Organizational Psychology* 86, no. 2 (June 2013): 242–263, https://doi.org/10.1111/joop.12015. Department of Veterans Affairs, *VHA HRO Framework*.

[28] Marcella Alsan, Owen Garrick, and Grant Graziani, "Does Diversity Matter for Health? Experimental Evidence from Oakland," *American Economic Review* 109, no. 12 (2019): 4071–4111, https://doi.org/10.1257/aer.20181446. "An inclusive environment enables Veterans and employees to feel safe, respected, engaged, motivated, and valued for who they are and their contributions toward organizational goals." Office of Health Equity, Veterans Health Administration, "Increasing Diversity in Recruitment and Advancement Across VA to Achieve Equitable Care and Outcomes," June 2023, https://www.va.gov/InfoBrief_IncreasingVAWorkforceDiversity_June2023_FINAL.pdf.

Through the All Employee Survey, the OIG found workplace diversity scores improved from FYs 2021 through 2023. Facility staff provided documentation on numerous special emphasis events held in FY 2023.[29] Leaders described encouraging participation through emails, social media posts, overhead announcements, electronic notice boards throughout the facility, staff meetings, and posters. In addition, leaders stated they had listening sessions with staff to discuss diversity, equity, and inclusion. The OIG concluded that executive leaders prioritized diversity and inclusion through collaboration and special emphasis events. The OIG made no recommendations.

[29] The special emphasis events focused on women's programs, sexual orientation and gender identity, Internal Holocaust Day, Limb Loss Awareness Month, National Minority Health Month, Juneteenth, National Prosthetic Sensory Aids Service Week, and Native American Heritage Month.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[30] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[31] 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.

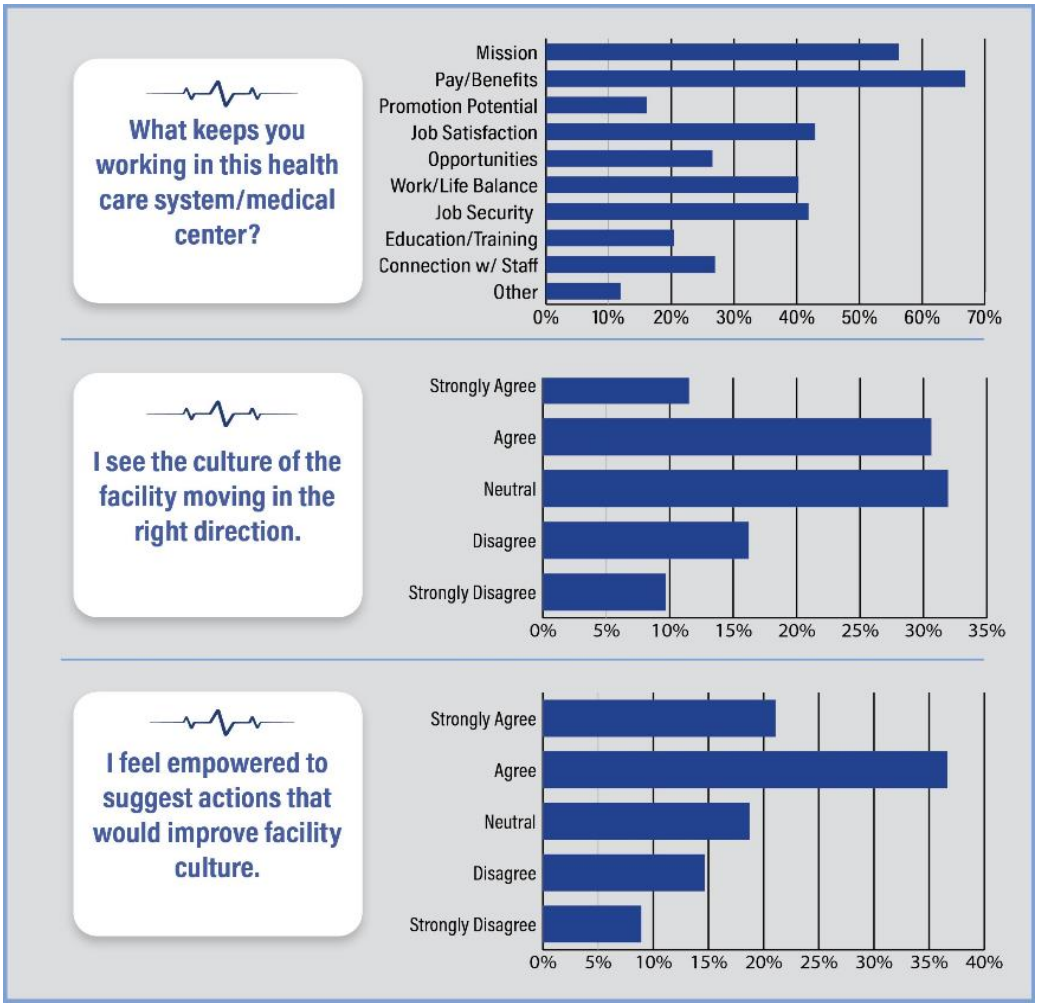


Figure 6. *Employee perceptions of facility culture.*
Source: Analysis of OIG-administered questionnaire responses.

[30] 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.

[31] 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 found that the All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety increased from FY 2022 to 2023. The executive leaders attributed the increases to their investment in the employee experience, which included establishing hotlines for reporting concerns or issues and using employee retention initiatives related to pay, benefits, and the student loan repayment program. Executive leaders described their support for innovation as part of a commitment to improving organizational culture for over 20 years. They discussed providing employees with an environment to test ideas to improve patient care, noting that frontline employees submit 30 to 40 innovative ideas every year.

The OIG-administered questionnaire responses supported the All Employee Survey results; 574 of the 764 respondents either agreed or strongly agreed with feeling comfortable reporting a patient or employee safety concern. Leaders reported believing employees were willing to report all issues and had a high level of confidence in knowing leaders would ask questions, actively listen, and take actions to address and resolve concerns. In responses to the OIG-administered questionnaire, most employees indicated that pay and benefits and the VA mission kept them working at the facility. Respondents also reported the culture of the facility was moving in the right direction, and leaders empowered employees to suggest ways to further improve. The OIG made no recommendations.

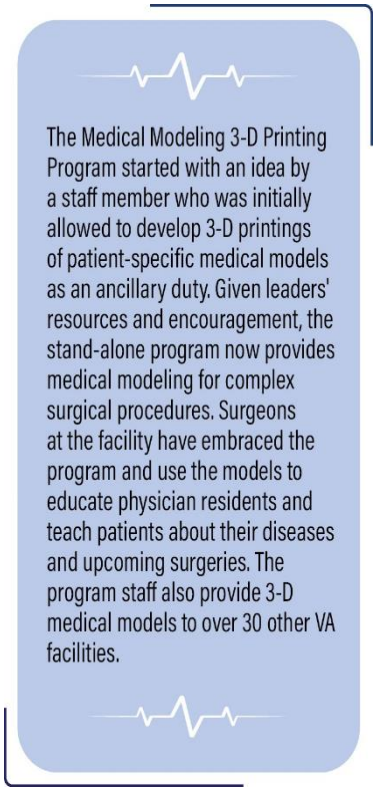


Figure 7. *Facility innovation: the Medical Modeling 3-D Printing Program. See appendix C for images of 3-D medical models. Source: OIG analysis of documents and interviews.*

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[32] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[33] The OIG reviewed patient advocate reports and a VSO questionnaire to understand veterans' experiences with the facility.

In a questionnaire response, the Patient Advocate noted the three most common veteran complaints were staff not answering their telephone calls to some outpatient clinics, concerns

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

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

with community care billing, and delays with receiving travel reimbursements. The Patient Advocate reported helping to resolve veterans' complaints, and leaders, service chiefs, and supervisors were supportive in these efforts.

Leaders stated they meet monthly with the VSOs and congressional stakeholders to discuss veterans' complaints and trends. Two of eight VSOs responded to an OIG questionnaire asking for feedback about working with the facility.[34] The VSOs identified some concerns from veterans: facility-canceled appointments, some providers appearing not to care about veterans, and veterans experiencing long appointment wait times for the sleep lab. Overall, VSOs responded they could provide feedback to facility leaders about the care provided to veterans, and leaders were responsive to them and to the veterans' concerns. The OIG made no recommendations.

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.[35] The OIG examined the general entry touchpoints, which are features that assist veterans in accessing the facility and finding their way around. To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints, including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 8. *The facility's main entrance.*
Source: https://www.va.gov/northeast-ohio-health-care/ (accessed April 26, 2024).

[34] The Disabled American Veterans and AMVETS (American Veterans) VSOs responded to the OIG's questionnaire.

[35] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[36] 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, Architectural Barriers Act guidelines, 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.[37]

Transit and Parking

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

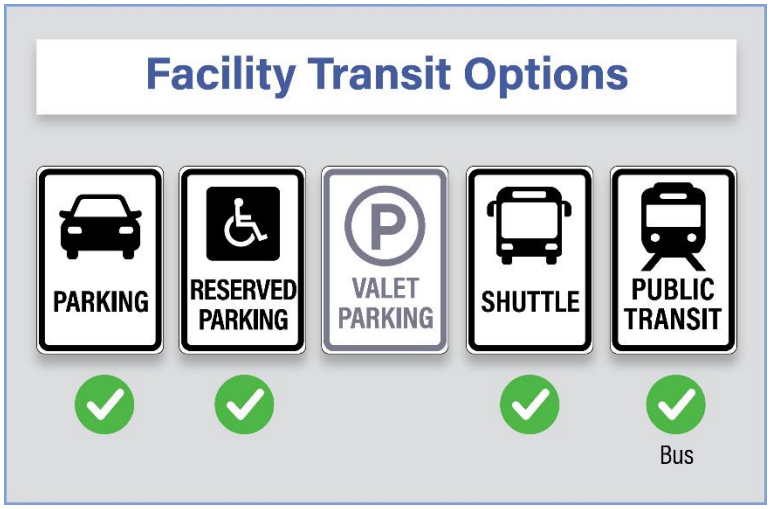


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The OIG team used the navigation link located on the facility's public website to obtain directions. The link guided the OIG team to the facility's main entrance. The OIG found that signs easily directed the team to the parking garages, where ample parking was available, including spaces accessible for those with disabilities. The OIG observed the parking garages were well-lit, with multiple security cameras on each level and the stairwells, and phones available for emergencies or to request escort services. A skywalk connected the parking garages to the facility. The OIG noted a public bus operated at a corner of the facility. The OIG made no recommendations.

[36] 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.

[37] 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.

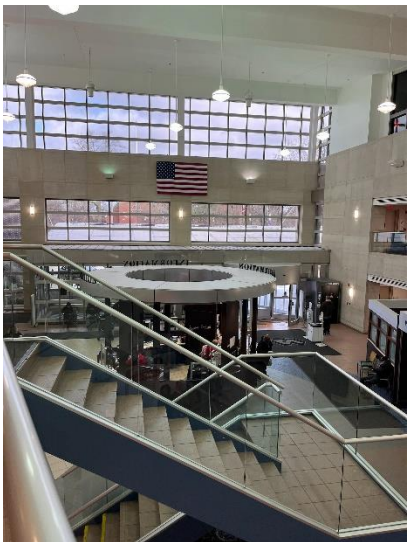


Figure 10. *Facility's information desk.*
Source: Photo taken by OIG inspector.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[38]

The OIG noted the facility had clear signs directing patients and visitors to the main entrance. The entrance exterior had a ramp and a passenger loading zone with an overhang to shelter patients and visitors. The entrance interior was an open, two-story atrium with large windows for natural light and additional lighting on the walls.

The information desk sat directly inside the main entrance, with three staff members seated at the desk and an escort desk situated nearby. The OIG observed staff actively serving patients and visitors at both the information and escort desks. The OIG noted ample seating areas near the information desk. Stairs and an elevator led to the second floor, where a vendor sold coffee, sandwiches, and snacks. The OIG made no recommendations.

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.[39]

The OIG found maps available online and at the skywalk entrance that connected the parking garages to the facility. The colored maps included clearly marked building names and other key areas on each floor. The facility's wayfinding kiosk provided personalized directions that were available in a printed version or through a mobile application.

[38] 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*.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[40] The OIG found that sensory-impaired veterans had access to the facility's mobile application that works with the wayfinding kiosk. The application provided veterans with verbal and written (large font) turn-by-turn directions. The OIG noted that signs and the elevator panels included braille and when the elevator doors opened, the current floor was announced, and a double ding sounded. The OIG also observed a therapist conducting a low vision and blind rehabilitation session, guiding the veteran down the facility corridors. The OIG noted the facility provides sign language interpretation services through an outside agency. The OIG made no recommendations.

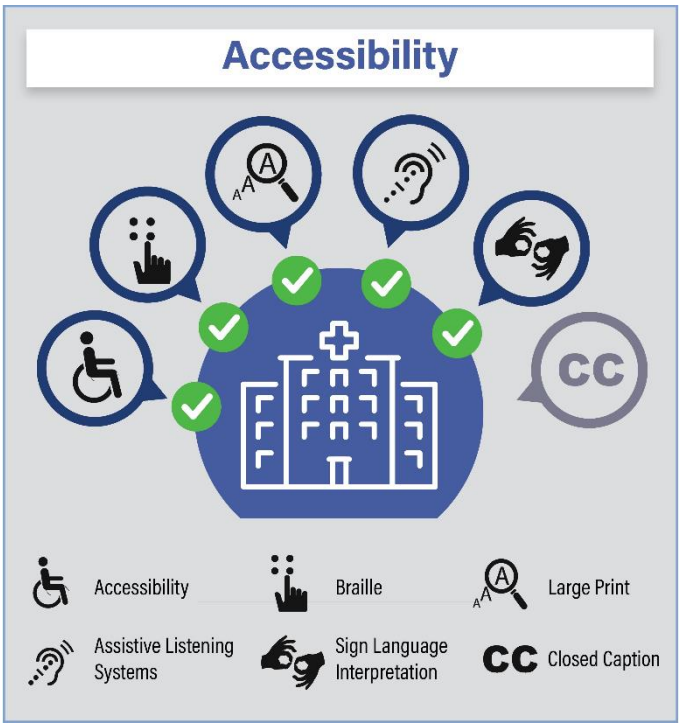


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[41]

As of April 3, 2024, the facility had completed approximately 87,000 toxic exposure screenings, with approximately 33,000 veterans reporting a toxic exposure. In an interview, a Toxic Exposure Screening Navigator described the facility's screening processes: a nurse screens veterans during their appointments, and if that initial screening indicates the veteran has been exposed to toxins, a provider performs a secondary screening. If the provider does not complete

[40] 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.

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

the secondary screening during the scheduled appointment, a clinical reminder in the electronic health record will indicate the exam is needed. A navigator monitors clinical reminders for veterans who need a secondary screening and contacts them to schedule the appointments. As of April 3, 2024, the OIG found the facility had zero clinical reminders that were more than 30 days overdue.

The OIG found staff conducted toxic exposure screening outreach at the facility's public town halls and had a provider and support staff present to provide or schedule screenings. The navigator reported no barriers with access, space, or wait times, and stated staff can accommodate same-day, walk-in screenings. The OIG made no recommendations.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[42]

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

The OIG found the facility met VHA's goals of staff closing environment of care deficiencies or creating an action plan to address them within 14 business days, and an executive leader attending inspection rounds more than 90 percent of the time in FY 2023.[43] Environment of care leaders discussed changing the approach of the rounds, which now includes huddles with the staff following rounds to share information and provide education. The OIG found staff tracked and resolved deficiencies and made no recommendations.

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.

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

[43] Acting Deputy Assistant Under Secretary for Health for Operations, "Fiscal Year (FY) 2023 Comprehensive Environment of Care (CEOC) Guidance (VIEWS 9547420)," memorandum to Veterans Integrated Service Network (VISN) Directors, February 21, 2023.

The OIG inspected four clinical areas and the Community Living Center's rehabilitation unit and found them all to be well-lit, clean, and free of clutter, with clear exit paths.[44] The OIG found that corridors, patient rooms, and bathrooms were clean, and heating and air conditioning vents were free of dust and dirt; although some high traffic areas showed wear, floors were also clean. The OIG observed patients moving or staff moving them through the halls without difficulty, medical equipment with current inspection stickers, and personal protective equipment readily available for staff use. Medications were securely stored near destruction bins, and none were expired or contaminated. The soiled utility room doors had black and red biohazard labels prominently affixed to them; and supply rooms were secure, clean, and orderly, with temperature monitors mounted on walls. The OIG also noted staff safeguarded patient privacy by using filters on computer monitors, facing monitors away from public view, and having privacy curtains and door locks in exam rooms.

The OIG also noted the Community Living Center's rehabilitation unit had recently been renovated and reopened on November 23, 2023. The OIG found the unit bright, inviting, and homelike. A spacious dining area and lounge, with nearly floor-to-ceiling windows along the far wall, overlooked the side of the main entrance and an open green field. The OIG observed plentiful snacks available on a table near the food storage room and residents' personal food marked with their name and date. Each of the spacious rooms had a large window, an ensuite bathroom, and comfortable furnishings. The OIG also noted safety features, such as easily activated pull cords at the head of the bed, in the shower, and by the toilet that produced an audible alarm and visible flashing light when pulled and secured handrails along the full length of both walls in the hallways. The OIG made no recommendations.

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.[45] Delayed or inaccurate communication of test results can lead to missed

[44] The OIG inspected the following clinical areas: emergency department, intensive care unit, medical/surgical unit, and Women's Care Clinic.

[45] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[46] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined the facility had processes to communicate abnormal test results to ordering providers, identify a surrogate provider outside regular clinic hours and when an ordering provider was unavailable or had left the facility, and indicate which noncritical results required follow-up. The Chief of Staff and quality management staff said they monitored the facility's data. For example, when data indicated a radiology provider did not communicate critical results as required, the radiologist received training. The OIG made no recommendations.

Action Plan Implementation and Sustainability

Figure 12. *Status of prior OIG recommendations. Source: OIG analysis of documents and interviews.*

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

The OIG reviewed oversight reports, surveys, and reviews involving the facility for the past three years and found only one review with a finding related to the communication of test results. The finding from VHA's Central Nursing Office noted the facility's policy did not yet align with VHA's directive. As of July 2024, the facility provided the OIG with their updated local policy that aligns with the VHA directive.[48]

Leaders and quality management staff explained the facility's process is to have staff from different departments collaborate on developing action plans to ensure sustained improvement. Quality management staff then monitor results over time and report them to executive leaders. The OIG did not identify any barriers to long-term improvements related to general patient safety. The OIG made no recommendations.

[46] 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.

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

[48] VHA Directive 1088. Facility Policy 011-098, *Ordering and Communicating Test Results,* July 8, 2024.

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.[49] 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.[50] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Chief of Staff and quality management staff told the OIG that one way they identify opportunities for improvement is through collaboration across departments to identify common themes. Staff reported bringing opportunities forward to leaders for discussion, development, and monitoring. Staff shared an improvement project involving how emergency department staff provide test results to discharged patients. The improved process involved a pharmacist reviewing a daily report of pending test results, notifying patients of their results, and working with the provider on duty if a medication change was required. Facility leaders informed the OIG they use a multi-modal approach to reinforce process improvement changes. The OIG made no recommendations.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[51] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[52] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

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

[50] VHA Directive 1050.01(1).

[51] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

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

staffing shortages.[53] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

After reviewing documentation provided by facility staff, the OIG learned that the facility's primary care clinics had a shortage of 18 administrative associates. The OIG found veterans did not experience increased appointment wait times or delays in care. In an interview, facility leaders attributed recruitment and retention challenges to the lengthy hiring process; candidates seeking remote work; and competitive private sector salaries. To address the challenges, leaders implemented pay incentives, recruited at community job fairs, and offered limited telework opportunities. Facility leaders informed the OIG they had hired additional primary care staff in anticipation of an increase in patient population during the pandemic. However, the facility experienced a decrease in veteran enrollment, which leaders attributed to slow population growth in the service area, veterans relocating to warmer climates, and veterans seeking care elsewhere. To counter the decrease in enrollment, leaders conducted outreach, held public town halls, and mailed information to veterans about the facility.

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.[54] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[55]

Facility leaders explained that VHA sets a goal for panel sizes nationally. The facility maintained a 90 percent or above panel fullness rate between July and December 2023. Primary care staff reported panel sizes and coverage expectations were reasonable given current staffing levels, and workload burdens had decreased recently due to implementing nurse triage clinics for walk-in patients and establishing pharmacy clinics for complex disease management. Staff reported meeting weekly with primary care leaders to adjust panels, assign new patients to panels, and discuss leave coverage and other primary care concerns. The OIG found that the average wait time for primary care appointments was 13 days for new patients. The OIG made no recommendations.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[56] Continuous process improvement is also one of the three

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

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

[55] VHA Directive 1406(1).

[56] VHA Handbook 1101.10(2).

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

In an interview, primary care staff said they have a supportive relationship with facility leaders who encouraged them to be creative and resourceful in developing process improvement projects. Staff also reported collaborating with the facility's informatics team to develop and implement projects to improve workflow and efficiency. Staff shared several examples of improvement projects, including nurse triage clinics (which staff suggested and leaders implemented) to decrease workload. In addition, staff developed a nurse protocol for patients with hypertension and an initiative for same-day access for telehealth.

Staff described frequent communication with leaders to discuss opportunities for improvement, including during committee and daily team meetings, and said leaders encouraged them to present their best practices and improvement projects in various forums. The OIG made no recommendations.

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. Based on an interview with executive leaders and responses to a questionnaire completed by the facility's Patient Advocate and two VSOs, there were no concerns or complaints related to the implementation of the PACT Act. Primary care team members stated the addition of screening for toxic exposure did not negatively affect their functioning. The OIG found that, in FY 2023, the average appointment wait time was approximately 7 days for established patients and approximately 13 days for new patients. The OIG made no recommendations.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[57]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[58] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[59]

In FY 2023, VHA exempted the facility from using the HCHV5 performance measure because the total number of unsheltered veterans in the facility's service area was too small to meet the target. HCHV staff discussed working with community partners to establish and maintain lists of all homeless individuals within the facility's service area, which they used to track outreach and engagement efforts. Per HCHV staff, at the time of the OIG interview, the lists included approximately 300 homeless veterans.

The facility's homeless primary care team is located within the Community Resource and Referral Center in Cleveland, Ohio. The team consists of providers, a nurse, a social worker, and an advanced medical support assistant. Recently, the team applied for and was awarded a Mobile Medical Unit. The unit allows the team to travel to homeless and at-risk veterans to provide direct medical care and clinical services.

Figure 13. *Homeless Primary Care Team and Mobile Medical Unit. Source: OIG analysis of a document and interviews.*

Staff voiced concerns about the accuracy of the point-in-time count because they felt it did not correctly capture the number of homeless individuals in rural parts of their service area. In an interview, the facility's Community Resource and Referral Center staff, who had offices in two locations, reported conducting outreach for the 22-county service area.[60] Staff said outreach included screenings that provided veterans with connections to resources and services. HCHV staff stated the focus of outreach was on veterans who were not engaged with other facility programs because sometimes veterans were apprehensive about services. According to staff, they allowed the veterans to build rapport with them at their own pace. The OIG made no recommendations.

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

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

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

[60] The Community Resource and Referral Centers are in Akron and Cleveland.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[61]

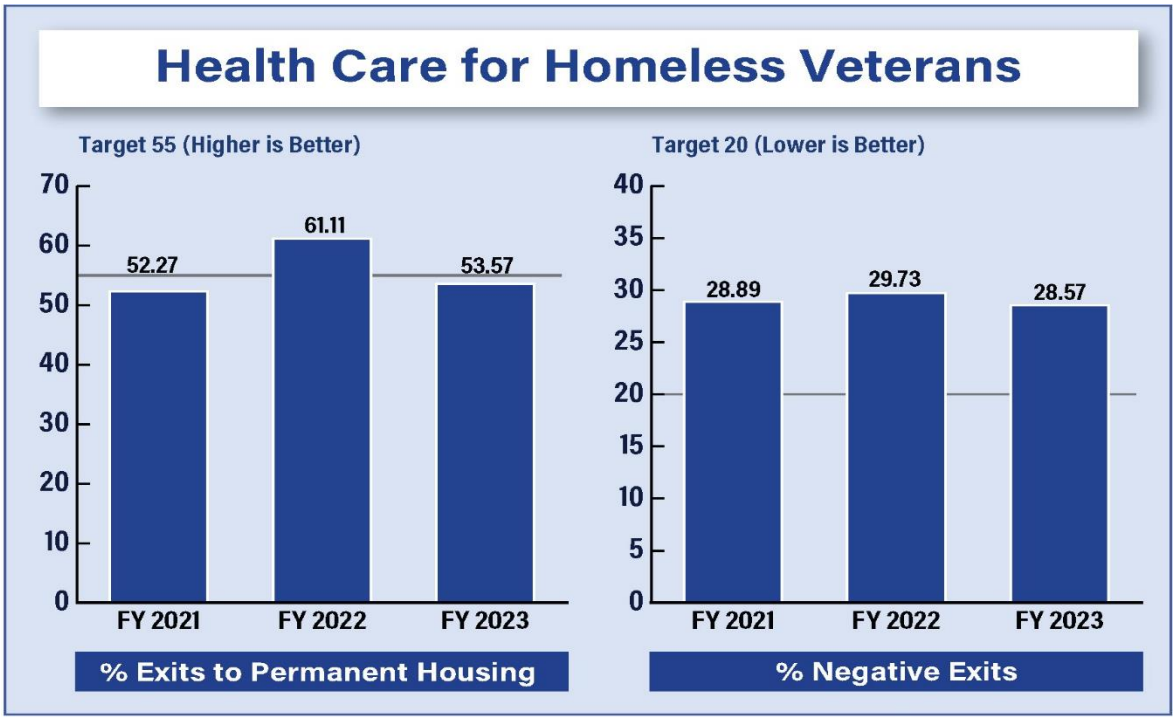


Figure 14. *National metrics for HCHV program.*
Source: OIG analysis of VHA Homeless Performance Measures data.

The program met the HCHV1 target for FY 2022 but not for FY 2023; it did not meet the HCHV2 target for either FYs 2022 or 2023. In an interview, HCHV staff explained that challenges to reducing the number of negative exits (discharges due to rule violations) included veterans' ongoing substance use. To address these challenges, staff said they worked on thoroughly screening veterans to direct referrals to housing programs that best meet individual needs. They also assisted veterans with mental health and substance use issues.

Program staff described recently working with aging veterans who may have never accessed homeless services. Staff added they coordinated veterans' care using referrals, case conferences, telephone calls, and electronic communication within VA, and met regularly with community partners outside VA.

[61] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above, and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

Further, HCHV staff described surveying veterans to assess their experiences with the facility's homeless programs and solicit their feedback and suggestions. In response to a veteran's request in the survey, staff set up groups for veterans to connect with each other. The OIG made no recommendations.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[62] 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.[63]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering veterans justice programs each fiscal year (performance measure VJP1).[64] The program met the performance measure target for FY 2023. At the time of the interview, program staff consisted of five veterans justice outreach specialists and one senior social worker. The staff served 11 veterans treatment courts and 18 prisons. In response to an OIG-administered questionnaire, a staff member explained that the goal was to identify veterans involved in the criminal justice system and engage them with VA services at the earliest possible point. Staff described their relationships with jails and prisons, highlighting that one jail currently has a veteran unit and another jail is in the process of establishing one; the new unit will allow program staff space to hold group meetings with veterans. The OIG made no recommendations.

A Veterans Treatment Court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager."

Figure 15. *Veterans treatment court. Source: VHA Directive 1162.06, Veterans Justice Programs, April 4, 2024.*

Meeting Veteran Needs

In response to an OIG-administered questionnaire, a staff member outlined some of the program objectives, including veterans engaging in recovery activity and treatment; using medical, substance use, employment,

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

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

[64] 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*.

housing, and social services; maintaining stable relationships with services after release from jail or prison; and building trust, a sense of hope, and self-esteem.

Staff discussed plans to explore community partners to target underserved areas and offer legal services. A staff member also saw an opportunity for improvement in encouraging court and jail coordinators to identify veterans as potential treatment court candidates at the point of detainment, allowing for an earlier connection with the program and its services. The OIG made no recommendations.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[65] 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.[66]

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).[67] The OIG found that despite staff's outreach, the program did not meet the performance measure target for FYs 2022 or 2023.[68] In an interview, the program coordinator attributed this to housing authority delays in completing required inspections, landlords not making identified repairs after inspections, and veterans not obtaining documents required by the housing authority. The coordinator stated that an outreach event in FY 2024 brought together veterans, program staff, landlords, housing authority staff, and community partners to collaborate on getting veterans housed. The coordinator said the event was successful and resulted in a 4 percent increase in the performance measure, adding that they planned to repeat the event later in the year. The OIG made no recommendations.

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

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

[67] 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*.

[68] The facility's HMLS3 score was 81.28 percent in FY 2022 and 79.23 percent in FY 2023.

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).[69] The OIG found the facility's program met the performance measure target for FY 2023. In an interview, the program coordinator attributed this to an employment specialist who met with veterans to understand their employment goals and interests, then identified appropriate job opportunities and school fairs.

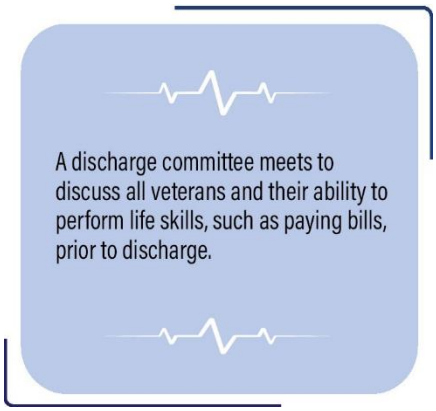


Figure 16. *Best practice for veteran engagement.*
Source: OIG interview.

The coordinator described a relationship with a housing unit that provided space for an on-site program social worker. The coordinator shared that to ensure the program met the needs of veterans, staff implemented performance improvement projects, such as adding suicide and food insecurity screenings to the assessment process. The coordinator added they partnered with VSOs and the Veterans Benefits Administration to assist veterans with clothing and applying for VA benefits. The coordinator identified a developing need for housing to meet the needs of aging veterans entering the program. The OIG made no recommendations.

Conclusion

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

[69] 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*.

Appendix A: Methodology

Inspection Processes

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from March 18 through 21, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[2] The OIG received responses from two VSOs: Disabled American Veterans and AMVETS (American Veterans).

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Race and Ethnicity	Race and Ethnicity	Census population by race/ethnicity are from the Census Redistricting Data (Public Law 94-171) Summary File, US Census Bureau.
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.

Category	Metric	Metric Definition
	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.
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.

Category	Metric	Metric Definition
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

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.

Category	Metric	Metric Definition
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.
	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 figures quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: Facility's Medical Modeling 3-D Printing Program

Figure C.1. *Cabinet holding various 3-D models the program produced.*
Source: Photo taken by an OIG inspector.

Figure C.2. *3-D model of a skull.*
Source: Photo taken by an OIG inspector.

Figure C.3. *3-D model of hand cyst.*
Source: Photo taken by an OIG inspector.

Figure C.4. *3-D model of an aortic aneurysm.*
Source: Photo taken by an OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 25, 2024

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

Subj: Healthcare Facility Inspection of the VA Northeast Ohio Healthcare System in Cleveland (541)

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

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

1. Thank you for the opportunity to review the draft report from OIG's Healthcare Facility Inspection of the VA Northeast Ohio Healthcare System in Cleveland.
2. I concur with the report, which included no recommendations.
3. Please contact the VISN 10 Quality Management Officer for questions or if additional information is needed.

(Original signed by:)

Laura E. Ruzick, FACHE

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 25, 2024

From: Director, VA Northeast Ohio Healthcare System (541)

Subj: Healthcare Facility Inspection of the VA Northeast Ohio Healthcare System in Cleveland

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the VA Northeast Ohio Healthcare System.
2. While the OIG made no recommendations for improvement, VA Northeast Ohio Healthcare System remains committed to continuously improving the quality and safety of Veteran care.
3. If you have any additional questions or need further information, please contact the Assistant Director for Quality and Patient Safety.

(Original signed by:)

Jill Dietrich Mellon, JD, MBA, FACHE
Executive Director/CEO

OIG Contact and Staff Acknowledgments

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

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 10: VA Healthcare System Serving Ohio, Indiana, and Michigan
Director, VA Northeast Ohio Healthcare System (541)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: Sherrod Brown, J. D. Vance
US House of Representatives: Troy Balderson, Shontel Brown, Jim Jordan, David Joyce, Marcy Kaptur, Robert Latta, Max Miller, Michael Rulli, Emilia Sykes

OIG reports are available at www.vaoig.gov.