US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Coatesville Healthcare System in Pennsylvania

Healthcare Facility Inspection	24-03207-161	July 10, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Coatesville Healthcare System (facility) from October 7 through 10, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. In an interview, executive leaders identified the COVID-19 pandemic and leadership turnover as system shocks that affected the organization's culture. During the pandemic, leaders increased communication with staff, implemented a COVID-19 screening process and single point of entry, and began holding outpatient appointments virtually.

The previous executive leadership team left the facility, which created instability for staff. Current executive leaders had only worked together since January 2024, and although still developing as a team, it appeared to the OIG they work well together and embrace high reliability organization principles.[2]

[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] High reliability organization principles include leadership commitment, safety culture, and continuous improvement. Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

The OIG found that All Employee Survey scores had improved between fiscal years 2022 and 2023 across various areas including communication and information sharing, best places to work, supervisory trust, and psychological safety.[3] Leaders attributed the improved scores to continuous efforts to ensure reliable communication and create an environment in which employees felt empowered to voice their concerns without fear of retaliation.

The OIG administered a questionnaire to all employees, and respondents largely feel comfortable reporting safety events and suggesting ways to improve their work environment. However, 45 percent disagreed or strongly disagreed the facility's culture is moving in the right direction. In an interview, leaders stated they are improving psychological trust through employee recognition awards, high reliability organization presentations, one-on-one coaching sessions, and conversations with employees. Leaders also reported they have a good relationship with veterans service organizations and meet with them regularly.[4]

Environment of Care

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

The OIG found the facility easy to navigate; it had ample parking throughout the site and a welcoming main entrance. The OIG observed road signs directing veterans to various buildings for clinical services, and each building had directional signs mounted on walls, as well as paper maps that were clear and easy to read. To aid veterans with sensory impairments, the OIG noted an audible tone when elevator doors opened and closed, and an available sign language interpretation service. Although leaders identified the facility's age and size as major barriers to maintenance, the OIG found the clinical and nonclinical areas inspected to be clean and well-maintained.

[3] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[4] 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.

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 facility had processes to manage test result communication, assign a surrogate provider when the ordering provider was on leave or had left the facility, and report test results outside regular clinic hours.

The facility did not have open recommendations from previous OIG reports. The OIG interviewed the Chief of Staff and quality management staff, who explained their process to create workgroups to address identified problems, develop reasonable action plans, and track recommendations. They also said they support process improvement projects and share the projects' results through patient safety forums; huddles; town halls; and the facility's annual Quality Week, where staff present the projects occurring across the facility.[5]

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[6]

Facility leaders reported only two part-time nursing vacancies at the Delaware County community-based outpatient clinic, and the OIG found these vacancies did not affect appointment wait times or access to care. Wait times averaged 15 days for new patients and less than 5 days for established patients across the facility.

Additionally, primary care staff described having a supportive relationship with facility leaders, who encourage them to be innovative in developing process improvement projects and improving workflows, adding that leaders provide feedback when staff bring concerns to their attention. For example, administrative assistants now use an electronic system to manage internal and external faxes. This process change has allowed for prompt delivery of information to appropriate team members.

[5] "A huddle is a daily micro-meeting that keeps teams united and informed." "Patient Safety Huddle Board," VHA National Center for Patient Safety, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.

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

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the facility had active homeless and veterans justice programs, with a strong emphasis on outreach, connections with multiple community partners, and creative approaches to meeting veterans' needs. However, staff from two housing programs reported limited housing and insufficient staffing as barriers that affected their ability to house veterans. The program coordinator said staffing has recently improved, and they hope to hire additional staff.

Staff acknowledged the new Director joined them on a recent visit to homeless encampments. When the OIG brought program staff's concerns to the attention of executive leaders, the Director discussed a plan to meet with them to hear their concerns. The OIG did not make a recommendation but encourages the Director to follow through with the plan.

What the OIG Recommended

Based on this inspection of the five content domains, the OIG has no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes C and D). No further action is required.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Coatesville Healthcare System
Coatesville, Pennsylvania
Level 3-Low Complexity
Chester County
Hospital Referral Region: Lancaster

Description of Community

POPULATION

Female **975,020**	Male **940,485**
Veteran Female **10,049**	Veteran Male **93,622**

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

MEDIAN INCOME

$70,057

EDUCATION

88% Completed High School
59% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **170**

SUBSTANCE USE

23.1% Driving Deaths Involving Alcohol
18.8% Excessive Drinking
507 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
3% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	727,397
Carpool	79,813
Work at Home	75,746
Walk to Work	29,102
Other Means	16,101
Public Transportation	15,145

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**15 Minutes, 9 Miles**
Specialty Care	**36 Minutes, 23 Miles**
Tertiary Care	**104 Minutes, 93 Miles**

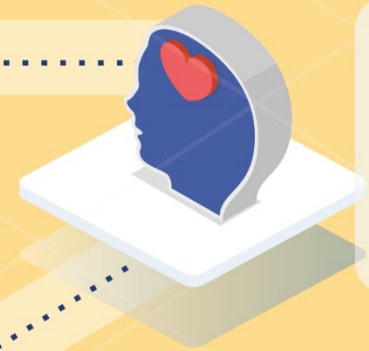
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **5,064**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	32%
<65 without Health Insurance	10%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

5,890

258 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

N/A

30-DAY READMISSION RATE

N/A

SUICIDE RATE PER 100,000

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

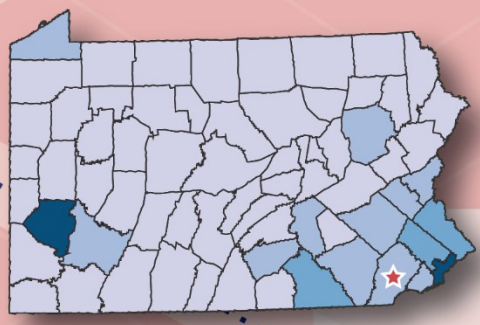
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	17K
Unique Patients VA Care	17K
Unique Patients Non-VA Care	4K

COMMUNITY CARE COSTS

Unique Patient $8,692	Outpatient Visit $315
Line Item $213	Bed Day of Care $343



STAFF RETENTION

Onboard Employees Stay <1 Yr	9.47%
Facility Total Loss Rate	14.60%
Facility Retire Rate	4.00%
Facility Quit Rate	9.30%
Facility Termination Rate	1.04%

★ VA MEDICAL CENTER

VETERAN POPULATION

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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

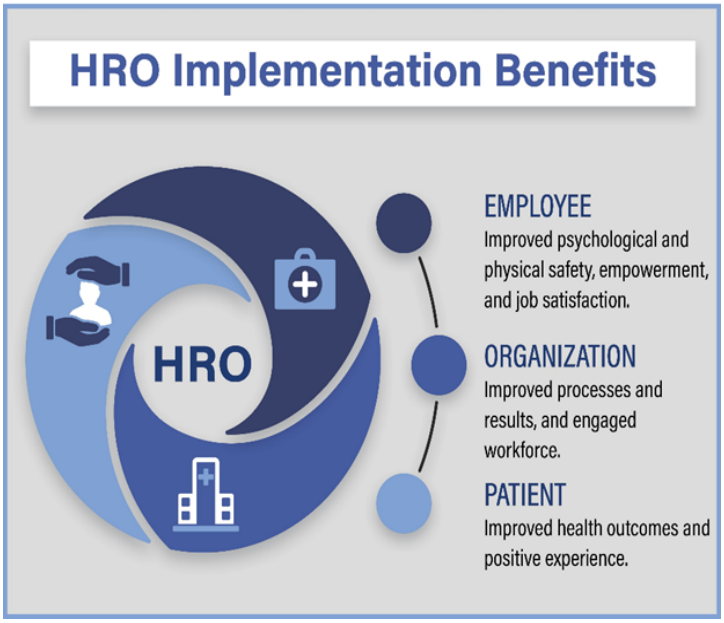


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

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

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

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

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

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

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; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

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

The VA Coatesville Healthcare System (facility) was built in 1929. In addition to the main site in Coatesville, the facility has two community-based outpatient clinics: the Delaware County VA Clinic and West Norriton VA Clinic. At the time of the inspection, the executive leaders consisted of the Executive Medical Center Director (Director); Chief of Staff; Associate Director, Patient Care Services/Nurse Executive; and Associate Director of Finance and Operations. The executive leadership team had worked together since January 2024, when the Associate Director of Finance and Operations was appointed. In fiscal year (FY) 2023, the facility had a medical care budget of $265,030,050, provided care to 17,004 patients, and had 302 operating beds (28 inpatient mental health, 148 domiciliary, and 126 community living center beds).[13]

CULTURE

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

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/DCHV. "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_CLC.

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

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

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

System Shocks

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

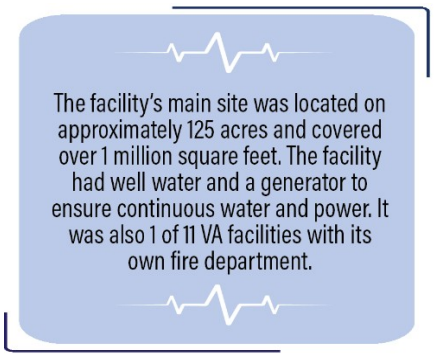


Figure 4. *Unique aspects of the facility. Source: OIG interview.*

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 and leadership turnover as system shocks.

Leaders discussed actions they took during the pandemic, which included increasing communication through town halls and daily huddles, implementing a COVID-19 screening process, and limiting access into the facility to one point of entry.[19] To reduce interpersonal contact, leaders enabled staff to conduct virtual appointments. They provided staff with laptops and patients with equipment, software, and an educational assessment to prepare them for virtual care. In addition, staff transformed an inpatient area into a negative pressure unit and developed a pool of staff to assist with screenings, conduct phone calls and contact tracing, and provide supportive services.[20] In the community living center and residential treatment areas, the facility implemented two zones—zone one for patients waiting on COVID test results and zone two for

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

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

[19] "A huddle is a daily micro-meeting that keeps teams united and informed." "Patient Safety Huddle Board," VHA National Center for Patient Safety, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.

[20] "Negative pressure is defined as air flowing out of a designated area thru a specified means of egress at a rate faster than it is entering the same area from adjacent areas or other specified means of ingress. This effectively prevents air from a 'contaminated area' entering any adjacent areas." Coatesville VA Medical Center, *Environmental Control Program for Tuberculosis*, August 2020. Contact tracing is "the practice of identifying, notifying, and monitoring individuals who may have had close contact with a person having a confirmed or probable case of an infectious disease as a means of controlling the spread of infection." *Merriam-Webster*, "Contact Tracing," accessed January 25, 2025, https://www.merriam-webster.com/ContactTracing.

those who tested positive. Facility staff used telehealth services to provide care for patients who tested positive.

Leaders stated the previous executive leadership team had been in place for many years, and they all departed the facility around the same time, which created instability for staff. Although it was a relatively new team, the OIG found the leaders worked closely together and promoted HRO principles.

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

The facility's All Employee Survey scores for communication, information sharing, and transparency improved from FYs 2022 to 2023. In an interview, leaders acknowledged the survey scores and credited the improvement to ensuring reliable communication. In the OIG-administered questionnaire, staff largely agreed leaders had changed how they communicate, and approximately one-third of the respondents reported the changes are an improvement and the information communicated is clear.

[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.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

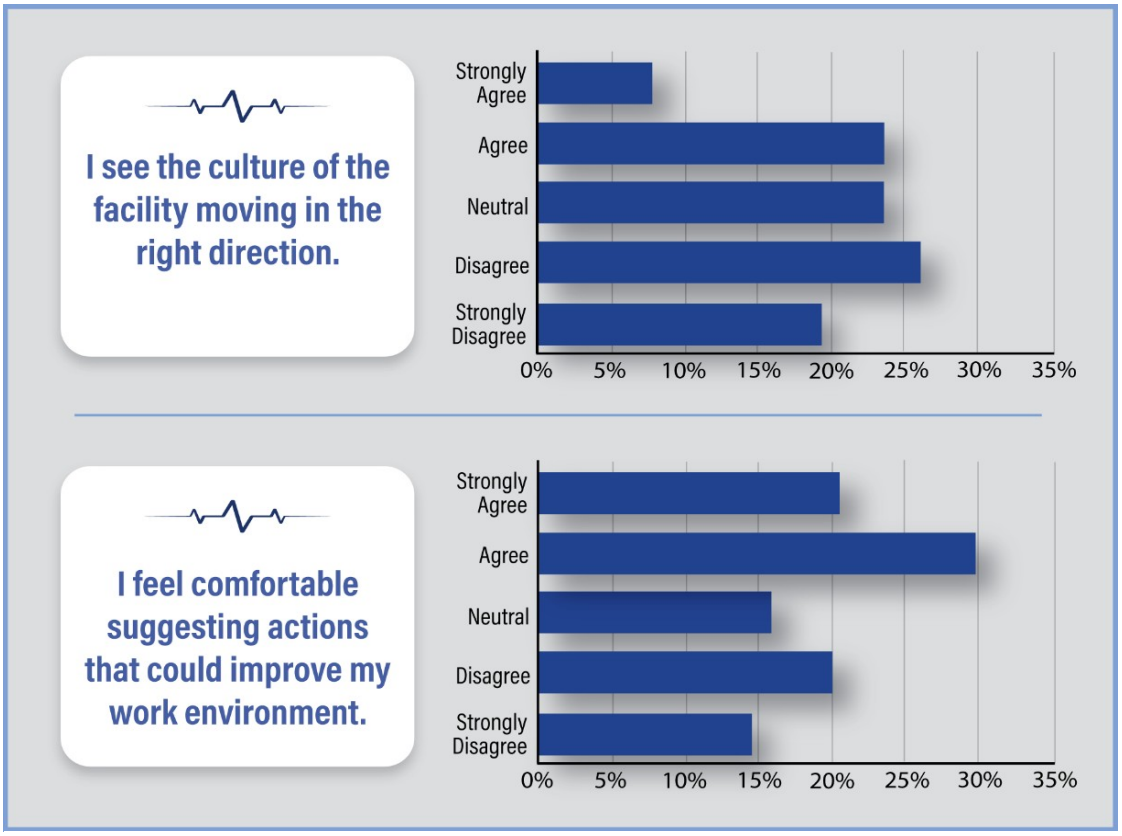


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

OIG questionnaire respondents largely indicated they feel comfortable reporting a safety concern and suggesting ways to improve their work environment. However, the OIG found that approximately 45 percent of respondents disagreed or strongly disagreed the facility's culture is

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

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

moving in the right direction. In an interview, executive leaders stated this score may be the result of executive leadership team turnover.

The OIG also found the All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety increased from FYs 2022 to 2023. Leaders attributed the higher scores to creating an environment in which employees feel empowered to voice their concerns and speak up without fear of retaliation. Leaders said they promote one-on-one coaching sessions and conversations with employees. They establish psychological trust through a variety of avenues, including recognition awards, HRO presentations, and Whole Health events (events that support health and well-being, such as walking groups and pet visits).[27] Additionally, leaders emailed current and prior VA survey data to employees, and the HRO Lead conducted listening sessions with them to better understand their perspectives. Finally, each department held working sessions to discuss the survey results and develop action plans to improve performance.

Veteran Experience

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

In an interview, executive leaders stated they have a good relationship with VSO representatives and conduct quarterly town hall meetings to share information about the facility. Based on the OIG questionnaire, a VSO representative indicated being able to provide feedback to leaders about veterans' care, and leaders are responsive to the representative and to veterans. In addition, leaders meet daily with the patient advocates to discuss issues and trends related to veterans' complaints.

[27] "Whole Health supports your health and well-being. Whole Health centers around what matters to you, not what is the matter with you." "Whole Health," Department of Veterans Affairs, accessed February 13, 2025, https://www.va.gov/wholehealth/.

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

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

ENVIRONMENT OF CARE

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

Figure 7. *Facility photo.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

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

[30] VHA Directive 1608(1).

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

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

Transit and Parking

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

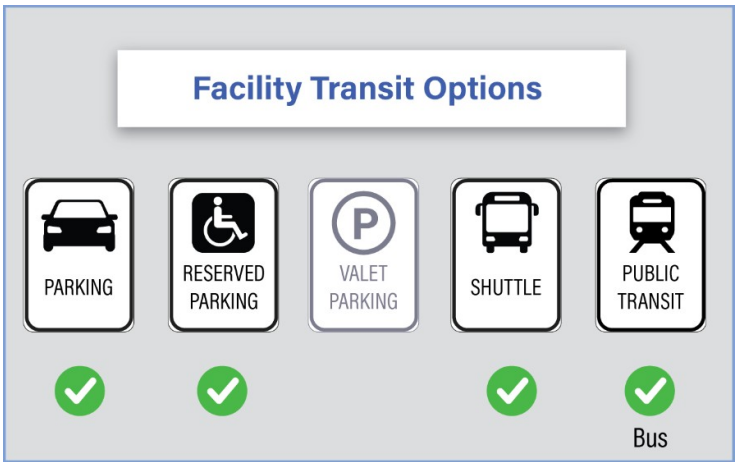


Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The OIG used the navigation link on the facility's public website to obtain directions to the main entrance. Road signs directed veterans to parking lots and to buildings for specific clinical services. Sheltered waiting areas located near parking lots were equipped with call boxes for veterans to request shuttle service and emergency assistance. The OIG found parking lots were well-lit with multiple streetlights and contained ample spaces, including reserved parking spots for veterans with limited mobility. The OIG reviewed the most recent Police Environment of Care Report and noted most VA police cameras were operational.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[33]

Although the facility had 42 buildings, building one was designated as the main entrance and the inspection team easily identified it as such. The OIG found two sets of stairs that led to the front door, signs that directed veterans to an accessible ramp with an automatic door, and clean wheelchairs at the entry point. The front desk had a police officer and staff member stationed to secure the area and assist veterans as needed. The cafeteria had a large seating area and a nearby store.

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

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

whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[34]

The OIG found the facility easy to navigate. The buildings had wall plaques and wall-mounted directional signs, stands with site maps that included a legend listing services provided in each building, and paper maps with the same information. The maps were clear, legible, and easy to read.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The OIG found signs with braille and large fonts throughout the facility. The elevators had an audible tone when doors opened and closed. The OIG also noted stair edges were brightly colored to aid visually impaired veterans in using the steps.

Based on documentation provided by the Lead Audiologist, facility staff use a sign language interpretation service as needed, and the Audiology Clinic provides hearing aids and other assistive devices to veterans to aid in navigation and daily activities.

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

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[36] The facility had two primary toxic exposure screening navigators. The OIG reviewed documents showing staff participated in 81 community events where they

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

[35] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

[36] Assistant Under Secretary for Health for Operations, "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.

presented toxic exposure screening information and found flyers about screenings available throughout the facility.

The OIG found staff screen most veterans during primary care and mental health appointments. Staff explained the screening process consists of two parts: nurses conduct an initial screen on all veterans, and providers complete a follow-up (secondary) screen on those who report exposure to a toxin during the initial screen. At the time of the OIG's site visit, staff had screened more than 13,000 veterans, and had six unresolved or overdue secondary screenings.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[37] 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 that because of the facility's large size and age, and the age of some equipment, staff had challenges with maintenance; performing routine maintenance on older equipment was cumbersome and time-consuming, and sometimes replacement parts were not available. However, leaders denied there were any chronically problematic areas, saying reports showed deficiency correction rates above 95 percent, and executive leaders had consistently attended environment of care rounds for the past eight quarters. The OIG did not identify any repeat findings.

General Inspection

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

The OIG inspected clinical and nonclinical areas throughout the facility and found them to be clean, with readily available personal protective equipment. The OIG also noted secured medications, and no expired medications and supplies. Equipment in exam and patient rooms was clean and had evidence of current safety inspections. Additionally, the OIG observed the community living center to be a homelike environment that maintained residents' privacy.

[37] 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.[38] 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.[39] 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 analyzed documents and interviewed executive and facility leaders and quality management staff and determined the facility had processes to communicate test results to ordering providers and patients, identify an alternate when an ordering provider was unavailable or had left the facility, and report test results outside regular clinic hours. Leaders also conduct audits through the External Peer Review Program to ensure providers notify patients of their test results within the required time frames.[40] The OIG found that for quarters two and three of FY 2024, the staff communicated abnormal test results that required action 91 percent and 88 percent of the time, respectively; and communicated those results within 30 days 100 percent and 94 percent of the time, respectively. Staff said leaders discuss these results, as well as patient safety goals, during regularly scheduled meetings.

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

[39] 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.

[40] 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).

Action Plan Implementation and Sustainability

Figure 10. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[41] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The facility had no open recommendations from oversight reports over the past three years. Staff said they establish workgroups that develop reasonable action plans to address any findings and recommendations. Staff regularly update facility committees about improvement projects, and quality management staff monitor the changes. Staff discussed the importance of buy-in when updating processes and said they focus on the positive effects on veterans' care to gain support from staff.

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.[42] 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.[43] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Staff said they often use VHA's patient safety reporting system to identify process improvement opportunities, in addition to ideas proposed by staff. Patient safety staff discussed process changes during monthly safety forums, alternating presentations with staff from other departments, such as the VA police, Environmental

> The Chief of Informatics and facility staff determined the electronic health record system deleted active medication orders when providers changed a patient's transfer or discharge order. The chief reported the problem to the Office of Information Technology, which addressed the problem nationally. By identifying and taking immediate action on this problem, facility staff and leaders prevented potential errors that could have affected patient care. The vigilance of facility leaders, and their dedication to a culture of continuous improvement helped to mitigate a risk before it escalated.

Figure 11. *Medication safety. Source: Facility staff.*

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

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

[43] VHA Directive 1050.01(1).

Management Service, and Infection Control. Facility leaders send calendar invites to all staff and record the sessions. Leaders said they also provide feedback to staff who enter concerns into the reporting system.

Staff highlighted that they present process improvement projects during the annual Quality Week. Quality management staff record the presentations and make them available for all staff to view through Microsoft Teams.[44]

Staff also said facility leaders support process improvement projects and are interested in assisting with any barriers that may arise. For example, executive and facility leaders instituted a process to discuss patient safety issues following the morning meeting to resolve them quickly. The OIG concluded that facility leaders and staff engage in continuous learning through process improvement.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[45] 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.[46] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[47] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, facility leaders reported vacancies at the Delaware County community-based outpatient clinic for a part-time licensed practical nurse and a part-time registered nurse. There were no provider or administrative assistant vacancies. The OIG found

[44] Microsoft Teams is a software product used by VA staff to collaborate "that combines chat, meetings, [and] calling." Department of Veterans Affairs, *VA Technical Reference Model v25.4,* "Microsoft Teams," accessed May 13, 2025, https://www.oit.va.gov/Services/TRM/ToolPage.

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

[46] 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).

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

the vacancies did not affect appointment wait times or access to care. In an interview, the facility's Primary Care Management Module Coordinator said the average wait times were 15 days for new patients and less than 5 days for established patients.[48]

Primary care staff explained that new patients were assigned to a team based on availability. For established patients, if their primary care team cannot schedule an appointment within two weeks, the team's registered nurse may see the patient in a walk-in clinic and then schedule a same-day appointment with the provider, if indicated.

Although there were no administrative assistant vacancies, facility leaders explained that recruiting and retaining staff in these positions was a challenge because of the long hiring process and competitive private sector salaries. Leaders also identified the lengthy onboarding process as a barrier to hiring providers.

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.[49] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[50]

In an interview, primary care staff stated panel sizes were reasonable. Staff attributed differences in panel sizes to providers' length of service: established providers had larger panels and newer providers had smaller panels during their first year of service.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[51] 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.

In an interview, primary care staff said they have a supportive relationship with facility leaders, who encourage them to participate on committees and be innovative in developing process improvement projects and improving workflow processes. Additionally, staff stated that when they report concerns, leaders update them on the outcomes.

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[48] The Primary Care Management Module is an "application that allows input of facility-specific and panel-specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." It "supports set-up and definition of the health care team, assignment of staff to positions within the team, and assignment of patients to the PACT [Patient Aligned Care Team]." VHA Handbook 1101.10(2).

[49] "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).

[50] VHA Directive 1406(1).

[51] VHA Handbook 1101.10(2).

Staff described initiating several recent process improvement projects. One involved administrative assistants using an electronic system to manage internal and external faxes, which allows for prompt delivery to appropriate team members. In another project, each primary care team identified a quality measure to focus on, working together to improve patient care. One team focused on a quality measure related to managing diabetes and another addressed high blood pressure. Primary care staff also said that to increase access to care, nurses implemented a triage system for walk-in patients, and pharmacists provide additional care for patients with high blood pressure or diabetes.

In another improvement effort, primary care staff changed the process for updating a patient's medication list. After patients check in for an appointment, they receive a list of their medications. The goal is for patients to review the list prior to the appointment and identify which medications they take regularly and which they stopped, or are not taking as prescribed. The nurse and provider then review the list with patients and document any changes. Staff said this new process has improved care coordination and patient satisfaction.

During the environment of care inspection, the OIG noted display boards in the Coatesville primary care clinics that provided information on staff coverage, training opportunities, and performance improvement projects. The Coatesville primary care team reported they discuss the information displayed on the boards during daily huddles.

Leaders explained they have an open-door policy and want to hear staff's suggestions on how to improve efficiency and patient care. They identified many venues to discuss staff concerns, including daily huddles, staff meetings, leader visits to work areas, and Microsoft Teams meetings.

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. Primary care and executive leaders reported the facility had the highest increase in veteran enrollment within their Veterans Integrated Service Network (VISN).[52]

Primary care staff stated the introduction of toxic exposure screenings initially affected primary care workflows because of the influx of newly enrolled patients who wanted screenings. However, the screenings did not currently affect team functioning, timeliness of care, or appointment wait times.

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

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.[53]

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).[54] 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."[55]

The program did not meet the HCHV5 target in FYs 2022 or 2023. In an interview, program staff said insufficient staffing was a barrier to meeting the measure. Staff stated the work became overwhelming and caused job turnover that left, at one time, only one homeless outreach social worker in the program. In FY 2024, the facility exceeded the performance target. The Program Supervisor attributed it to the program now having five outreach social workers and a coordinated entry specialist, as well as working with community partners to identify homeless veterans and enroll them in the program.

Additionally, program staff explained the point-in-time count was useful but not necessarily accurate for counting unsheltered veterans. They described better ways to identify these veterans, such as connecting with county-based homeless programs. For example, the Coordinated Entry Specialist could access a county's homeless lists for a real-time count of homeless veterans and

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

[54] VHA sets escalating targets for this measure at the facility level VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[55] 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.

non-veterans in the community. Program staff have also increased their outreach effort over the past two years by visiting homeless encampments and developing cards with program contact information to hand out to veterans and community partners.

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).[56]

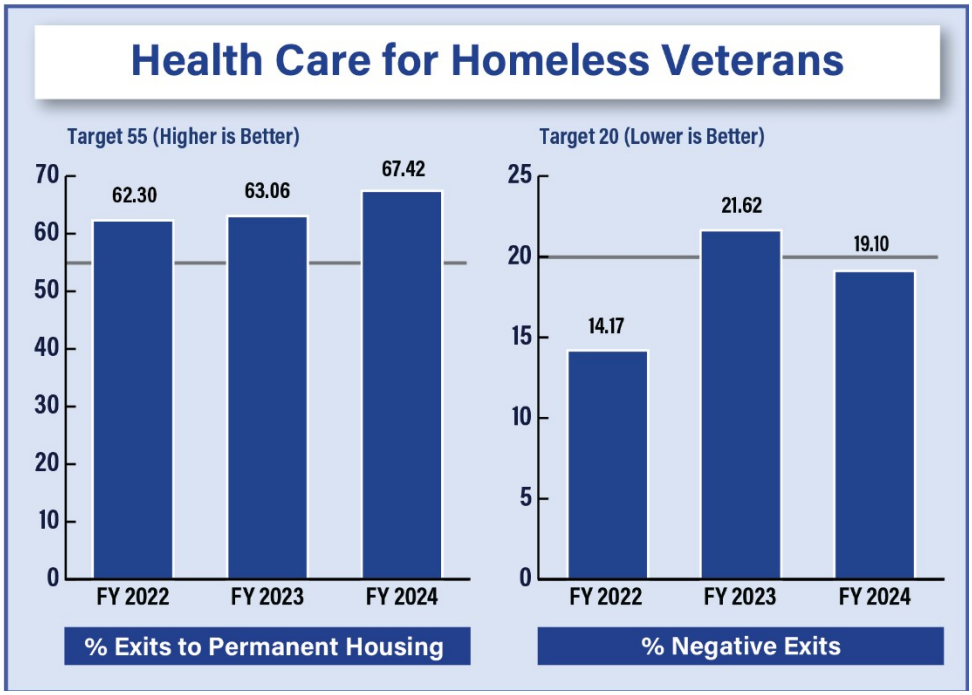

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The facility met the HCHV1 target for FYs 2022 through 2024. The facility also met the HCHV2 target for FYs 2022 and 2024 but missed it by 1.62 percent in FY 2023. Although the program met many of the targets, staff identified several barriers affecting the veterans served, including challenges working with primary care staff to get them to provide timely medical clearances, so veterans could participate in residential programs. Additionally, in March 2023, program staff said the VA grant-funded housing program and a community-based transitional housing program

[56] 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*.

in one county ended.[57] The loss of the beds increased the number of unsheltered veterans and amplified the challenges in getting veterans housed quickly. Staff reported veterans had access to short-term housing options, such as hotels for one or two week periods but this option was limited. To address the loss of beds, staff worked closely with counties' homeless programs to coordinate care and services. For example, program staff said one county has a coordinated entry system, where local homeless agencies cooperate to ensure homeless veterans receive timely interventions, such as shelter services. Program staff explained that because they maintain a good rapport with the county's homeless program, those staff call them when veterans are in county shelters. Additionally, the HCHV Social Work Supervisor stationed a program staff member at a local shelter, which allowed them closer access to veterans to provide VA services.

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."[58] 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.[59]

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).[60] The program met the target for FY 2024.

In an interview, the Housing and Urban Development–Veterans Affairs Supportive Housing Coordinator stated the program serves three counties and has 602 housing vouchers (502 in Chester County, 80 in Delaware County, and 20 in Montgomery County). According to the facility's organizational chart, the program has a supervisory social worker, nurses, peer specialists, social workers, a social science program specialist, and a vocational rehabilitation

[57] VHA homeless programs use transitional housing options to temporarily shelter veterans if they cannot immediately place them into permanent housing option. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

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

[60] 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*.

specialist. The coordinator explained the program should have a support staff member to assist with monitoring data and entering intake information. However, this position has been vacant for the past three years. The coordinator reported challenges with recruiting program staff due to a heavy and challenging caseload, as well as requirements for staff to work independently and predominantly within the community. The coordinator stated they recently hired two new staff members who are making a difference, and they hope to have additional staff soon.

In addition, program staff identified the lack of affordable housing and limited transportation options as barriers in meeting the performance target. According to staff, the facility's service area encompassed three counties with one being the most expensive in Pennsylvania, which makes it difficult to find affordable housing and landlords willing to accept housing vouchers.

Staff also identified challenges veterans face working with the facility's primary care teams and their lack of knowledge regarding homelessness. To improve primary care access and services for homeless veterans, staff said they have been asking executive leaders to establish a homeless primary care team since 2011 to streamline and coordinate care.

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).[61] The program met the targets for FY 2022 through FY 2024. Staff explained the program's Employment Specialist has many connections in the community and actively works to find veterans employment and assists with resume writing.

In the OIG-administered questionnaire, the coordinator stated that the program's Housing Specialists met regularly with community partners, outreach staff, and housing authorities to review cases, coordinate next steps, and identify any obstacles that may prevent veterans from obtaining housing. The coordinator further said staff rely on community partners to assist veterans with locating rentals, securing temporary housing while waiting on rental units, and paying costs such as security deposits. In an interview, staff explained they work with two non-profit programs that offer and store mattresses and furniture until veterans need them.

Program staff said they feel the program is successful because they see veterans going from being homeless most of their lives to living in an apartment, with some working at the facility. However, staff mentioned a lack of leadership support, saying they shared concerns with executive leaders but remain unaware of any outcomes. Staff also described feeling isolated and

[61] 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*.

not recognized, although they noted a change with the new Director, who spent a day with them at homeless encampments.

During a briefing with the executive leadership team, the OIG brought up these concerns. Following the meeting, the Director described plans to reach out directly to program staff and schedule meetings to hear about their concerns. The OIG did not make a recommendation but encourages the Director to follow through with this planned interaction.

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 FY (performance measure VJP1).[64] The facility exceeded the target for FYs 2023 and 2024. Program staff stated they assist veterans whether or not they are eligible for VA services (although ineligible veterans are not included in the performance measure). The program's three staff members cover the three counties in the facility's service area, each with a veterans treatment court.[65] Program staff received referrals from facility social workers, veterans, probation officers, and lawyers.

Although the three veterans treatment courts had differences, each program lasted from 18 to 24 months and accepted veterans charged with driving offenses, simple assaults, and domestic violence; none accepted major crime cases. For domestic violence cases, veterans could also

[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*.

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

participate in individual therapy, anger management classes, and the Strength at Home program.[66]

Staff said Montgomery County established a Veterans Response Team two years ago and there are plans to expand the program to Delaware and Chester county. The Veterans Response Team, made up of community hospital staff, community police officers, and VA staff, is a deflection program where the team works to help veterans avoid being arrested and instead receive mental health services.[67] Staff provided an example where a police officer called the Veterans Response Team to talk with a veteran, and eventually took the veteran to a local hospital instead of jail.

Meeting Veteran Needs

In the OIG-administered questionnaire, program staff identified challenges their veterans face in accessing care at the facility. For example, when a veteran is accepted into a residential program, there is a requirement to be admitted by a certain time of day. However, for veterans coming from a jail, program staff cannot ensure the veterans arrive by a certain time because the release from jail is determined by the court system. Program staff said they often must negotiate with the residential program to accept the veteran outside their designated time.

In an interview, staff noted stigma as a barrier within the community, specifically related to housing. Sex offenders presented challenges both with housing and participation in the treatment courts. Despite these difficulties, staff described several successes. For example, a veteran graduated from the program three years previously and became a mentor. Another veteran who worked with program staff had frequently been jailed but was now sober and had secured an apartment and a job. The OIG found the program staff advocated for their veterans both within the justice system and with obtaining VA services.

[66] "Strength at Home is a trauma-informed and evidence-based group program for Veterans who struggle with conflict in their relationships.…Groups focus on providing education and therapy related to trauma and aggression and teach conflict management skills to deescalate difficult situations, assertiveness training, and communication skills." "VHA Social Work, Intimate Partner Violence Assistance Program (IPVAP) – VETERANS AND PARTNERS – What Can I Do?," Department of Veterans Affairs, accessed January 25, 2025, https://www.socialwork.va.gov/WhatCanIDo/Strength_Home_Program.

[67] Deflection programs are "pre-arrest diversions, to reduce or prevent negative outcomes through supportive health care services." "First Responder Deflection Support Services," Department of Veterans Affairs, accessed February 12, 2025, https://www.va.gov/first-responder-deflection-support-services.

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.

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 two VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from October 7 through 10, 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.

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

[2] The OIG sent questionnaires to two VSOs (Disabled American Veterans, and Veterans of Foreign Wars). The OIG received a response from one VSO (Disabled American Veterans). VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/veo/traditionalVeteranOrganizations.pdf.

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

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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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 16, 2025

From: Denise Boehm Acting Director, VISN 4: VA Healthcare (10N04)

Subj: VA OIG DRAFT REPORT: Healthcare Facility Inspection of the VA Coatesville Healthcare System in Pennsylvania

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

Director, Office of Healthcare Inspections (54HF02)

I have reviewed the VA OIG Draft Report: Healthcare Facility Inspection of the VA Coatesville 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: June 10, 2025

From: Jennifer Harkins, Executive Director, VAMC Coatesville (VISN 04)

Subj: VA OIG DRAFT REPORT: Healthcare Facility Inspection of the VA Coatesville Healthcare System in Pennsylvania

To: Director, VISN 4: VA Healthcare (10N04)

I have reviewed the responses provided by VA OIG DRAFT REPORT: Healthcare Facility Inspection of the VA Coatesville Healthcare System in Pennsylvania and I concur with the report and recommendations. I am submitting to your office as requested.

(Original signed by:)

Jennifer Harkins, MS, FACHE
Executive Medical Center Director

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