US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Central Ohio Health Care System in Columbus

Healthcare Facility Inspection	24-00593-181	August 6, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Central Ohio Health Care System (facility) from September 24 through 26, 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 two system shocks: implementation of the Oracle electronic health record system and the COVID-19 pandemic's effect on how veterans received care.[2] Executive leaders said they responded to these system shocks by hiring more staff to meet the added workload created by the Oracle system and offering veterans virtual appointments. Based on their responses to an OIG questionnaire, staff felt executive leaders' actions had effectively addressed the system shocks.

While All Employee Survey scores related to communication remained consistently near the VHA average, executive leaders shared that they had increased communication through weekly

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

[2] "VA's Electronic Health Record Modernization (EHRM) program is managing the transition from VA's current medical records system, Veterans Health Information Systems and Technology Architecture (VistA), to the Federal EHR." "VA EHR Modernization, Frequently Asked Questions," Department of Veterans Affairs, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

newsletters and visits to staff in their work areas.[3] However, the high reliability organization lead said some leaders used a standardized process to convey information from executive leaders, such as during morning meetings, but it was not consistent across the facility.[4] The lack of consistency by leaders resulted in staff missing information. The high reliability organization lead provided the OIG with a plan to continue developing a standardized process to ensure consistent service-level communication. The OIG made a recommendation for this finding.

The facility's best places to work score fell in fiscal year 2022 but improved in fiscal year 2023.[5] Executive leaders said scores improved because they created focus groups to obtain feedback from employees and developed action plans to address their concerns.

In an OIG questionnaire, patient advocates identified veterans' inability to directly contact their VA medical team by phone as a concern.[6] An executive leader said this began when Veterans Integrated Service Network (VISN) leaders routed veterans' calls to a VISN call center.[7] Executive leaders said they were working with VISN leaders to address this concern.

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's transit and parking options to be adequate, and the main entrance appeared welcoming. The facility had available wheelchairs, as well as large-print and braille signs, which helped veterans with navigation. However, the OIG noted dirty floors and damaged walls, which are infection risks, in two patient care areas and made a recommendation.

[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 Organizational Development.

[4] High reliability organizations focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings. Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[5] The best places to work score "is a weighted average of job satisfaction, organization satisfaction, and whether people would recommend VA as a good place to work." "VA All Employee Survey," Department of Veterans Affairs, accessed August 6, 2024, https://www.datahub.va.gov/stories/s/VA-All-Employee-Survey-AES.

[6] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

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

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility had established processes to inform ordering providers and patients about abnormal test results. The Chief of Quality, Safety and Innovation stated staff also audit providers' communication of test results to patients to identify opportunities for improvement.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[8]

Although primary care teams had vacancies among provider, nurse, and administrative associate positions and veteran enrollment increased 4.75 percent, the OIG did not find increased appointment wait times or delays in care. However, primary care staff identified issues with VISN call center staff mishandling appointments. They said when veterans call the VISN call center, staff sometimes schedule their appointments or send secure messages to the wrong providers. The OIG did not make a recommendation but suggest VISN and facility leaders collaborate to resolve the issue.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans into the programs and how well they meet veterans' needs. The facility had effective homeless and justice programs that covered 14 counties.

The Chief of Behavioral Health stated the Oracle electronic health record system posed challenges for the homeless programs. The chief explained the system's workflow was cumbersome and did not capture productivity or allow essential database functions. Program leaders elevated their concerns to the national homeless program office but have not received a response.

The Housing and Urban Development–Veterans Affairs Supportive Housing program had a 30 percent staff vacancy rate, and staff reported feeling burnout and emotional stress. The Chief

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

of Behavioral Health described using ongoing recruitment efforts and hiring incentives to fill the vacancies. The OIG made a related recommendation.

What the OIG Recommended

The OIG made three recommendations.

1. Facility leaders implement a standardized process for service-level communication to consistently disseminate information.
2. Facility leaders ensure Environmental Management Services staff keep patient areas clean and walls intact to minimize the spread of infection.
3. The Medical Center Director evaluates the allocation of resources to ensure the Housing and Urban Development–Veterans Affairs Supportive Housing program meets the needs of the veterans served.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, and the responses within the body of the report for the full text of the directors' comments). Based on the information provided, the OIG considers recommendations 1 through 3 closed. 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 Central Ohio Health Care System
Columbus, Ohio
Level 2-Medium Complexity
Franklin County
Hospital Referral Region: Columbus

Description of Community

POPULATION

Female **2,558,701**	Male **2,505,859**
Veteran Female **30,350**	Veteran Male **279,398**

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

MEDIAN INCOME

$53,644

EDUCATION

89% Completed High School
54% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **114**

SUBSTANCE USE

28.7% Driving Deaths Involving Alcohol
18.4% Excessive Drinking
2,246 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	1,911,286
Carpool	183,270
Work at Home	141,813
Walk to Work	54,255
Other Means	32,186
Public Transportation	20,895

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**25 Minutes, 20 Miles**
Specialty Care	**59 Minutes, 54.5 Miles**
Tertiary Care	**125 Minutes, 127.5 Miles**

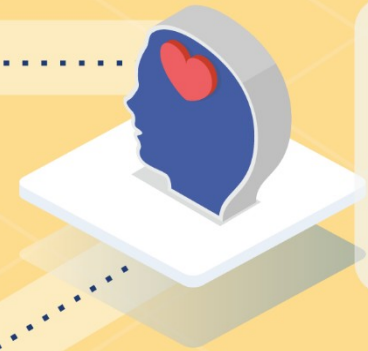
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **11,332**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	29%
<65 without Health Insurance	11%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

10,898

N/A 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)
19	34

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	45K
Unique Patients VA Care	41K
Unique Patients Non-VA Care	22K

COMMUNITY CARE COSTS

Unique Patient $28,665	Outpatient Visit $320
Line Item $837	Bed Day of Care $295

STAFF RETENTION

Onboard Employees Stay <1 Yr	15.57%
Facility Total Loss Rate	11.11%
Facility Retire Rate	1.65%
Facility Quit Rate	8.55%
Facility Termination Rate	0.79%

★ VA MEDICAL CENTER

VETERAN POPULATION

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

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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

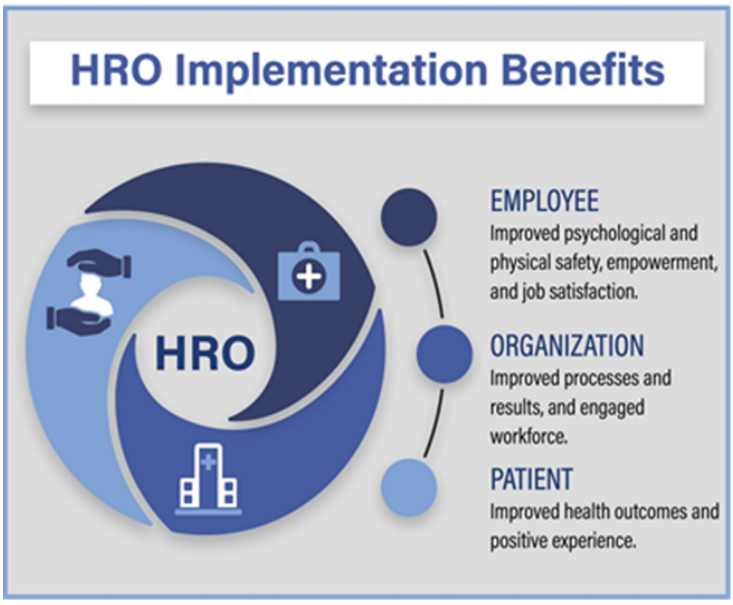


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

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

PACT Act

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

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

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

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and 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 Central Ohio Health Care System (facility) opened in 1974. During the inspection, executive leaders confirmed the facility provided outpatient care only and did not have inpatient beds or an emergency room. At the time of the inspection, the facility's executive leaders consisted of the Medical Center Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and Assistant Director. The newest member of the leadership team, the Chief of Staff, was assigned in October 2022. The Associate Director for Patient Care Services, assigned in March 2018, was the most tenured. In fiscal year (FY) 2024, the facility's budget was approximately $600 million.

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."[13] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[14] 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).[15]

[13] 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.

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

[15] 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.[16] 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.[17]

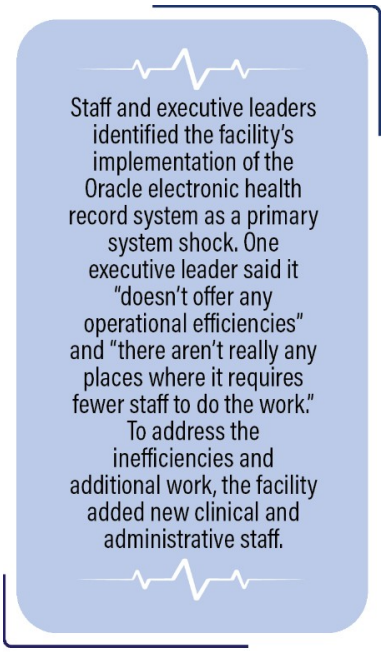


Figure 4. *System shocks. Source: OIG interview with executive leaders.*

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 two system shocks: implementation of the Oracle electronic health record system and the COVID-19 pandemic's effect on how they provided care.[18]

Of the 556 respondents to the OIG questionnaire, 76.3 percent identified implementation of the new electronic health record system as the primary system shock. Executive leaders reported that Oracle staff did not adequately train facility staff before its implementation, and the system increased their workload by making previous tasks, like entering medical data, more time consuming. In response, they hired more staff and established an incident command center to address issues as they arose.[19] Further, an executive leader said facility staff joined national committees and councils related to VHA's implementation of the Oracle system. According to the Assistant Director, this allowed staff to advocate for the facility when national leaders made

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

[17] 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*.

[18] "VA's Electronic Health Record Modernization (EHRM) program is managing the transition from VA's current medical records system, Veterans Health Information Systems and Technology Architecture (VistA), to the Federal EHR." "VA EHR Modernization, Frequently Asked Questions," Department of Veterans Affairs, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

[19] During an incident "requiring immediate actions" and "change from routine management methods," VHA uses the Incident Command System, which includes "standardized organizational structure with common terminology" to manage the change effectively. VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

decisions about the system. Additionally, executive leaders briefed members of Congress monthly to inform them about the progress of the system's implementation and any challenges experienced along the way.

During the COVID-19 pandemic, VHA leaders directed staff to minimize the number of people who came into the facility to decrease the spread of the virus.[20] The executive leaders praised staff for transitioning from in-person to virtual care, offering new telehealth appointments for veterans, and strengthening virtual communication between staff and veterans. An executive leader admitted that veterans' trust scores from VA's VSignals surveys declined during the pandemic but later rebounded because of these actions.[21] The OIG noted that staff also felt executive leaders' actions had effectively addressed this and the other system shock, based on their responses to the OIG questionnaire.

Leadership Communication

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

Figure 5. *Executive leaders' communication with staff. Source: OIG interview with executive leaders.*

[20] Deputy Under Secretary for Health for Operations and Management (10N), "Guidance to Avoid All Routine or Non-urgent Face to Face Visits," memorandum to Veterans Integrated Service Network (VISN) Directors, March 31, 2020.

[21] VA measures veteran trust through quarterly surveys sent through the VSignals platform. "Veteran Trust in VA," Department of Veterans Affairs, accessed January 22, 2025, https://www.va.gov/initiatives/veteran-trust-in-va/.

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

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

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

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

When asked about barriers to communication, executive leaders stated that staff received outside guidance from multiple sources that was not clear. An executive leader shared an example of when VHA leaders sent staff multiple emails about when veterans should resume copays for medications. The emails contained different days and months for when staff would collect copays, which differed from what executive leaders said; those mixed messages confused staff. To overcome this barrier, leaders (executive and pharmacy) worked together, determined which date was accurate, and shared the information with staff.

The OIG found that VA All Employee Survey scores for executive leader communication, transparency, and information sharing had improved from FYs 2022 to 2023 and remained consistently near the VHA average. The HRO lead said some facility leaders had begun to share information from the executive leaders with their staff during morning meetings. However, the HRO lead stated this process did not occur in every service and resulted in staff missing information. The HRO lead provided the OIG with a plan to continue developing a standardized process to spread information across all services to ensure consistent communication. The OIG recommends facility leaders implement a standardized process for service-level communication to ensure consistent information dissemination.[26]

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28] 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 reviewed survey questions and leaders' interview responses related to psychological safety. The OIG also examined All Employee Survey data from FY 2021 to FY 2023 and noted the best places to work score fell in FY 2022.[29] Executive leaders attributed some of the score's decline to the Oracle implementation and a lengthy investigation of a facility leader. Specifically,

[26] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

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

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

[29] The best places to work score "is a weighted average of job satisfaction, organization satisfaction, and whether people would recommend VA as a good place to work." "VA All Employee Survey," Department of Veterans Affairs, accessed August 6, 2024, https://www.datahub.va.gov/stories/s/VA-All-Employee-Survey-AES.

executive leaders said they conducted an administrative investigation that took approximately a year to complete.[30]

During the year, the Chief of Staff said leaders kept employees up to date on the progress, but did not disclose specific details due to the sensitive nature of the investigation. Executive leaders stated that because of this, employees became anxious and thought they were not being transparent with information. To address the employees' concerns, executive leaders said they communicated the extensive steps involved in an investigation. The Associate Director added that employees seemed less stressed after they understood the process.

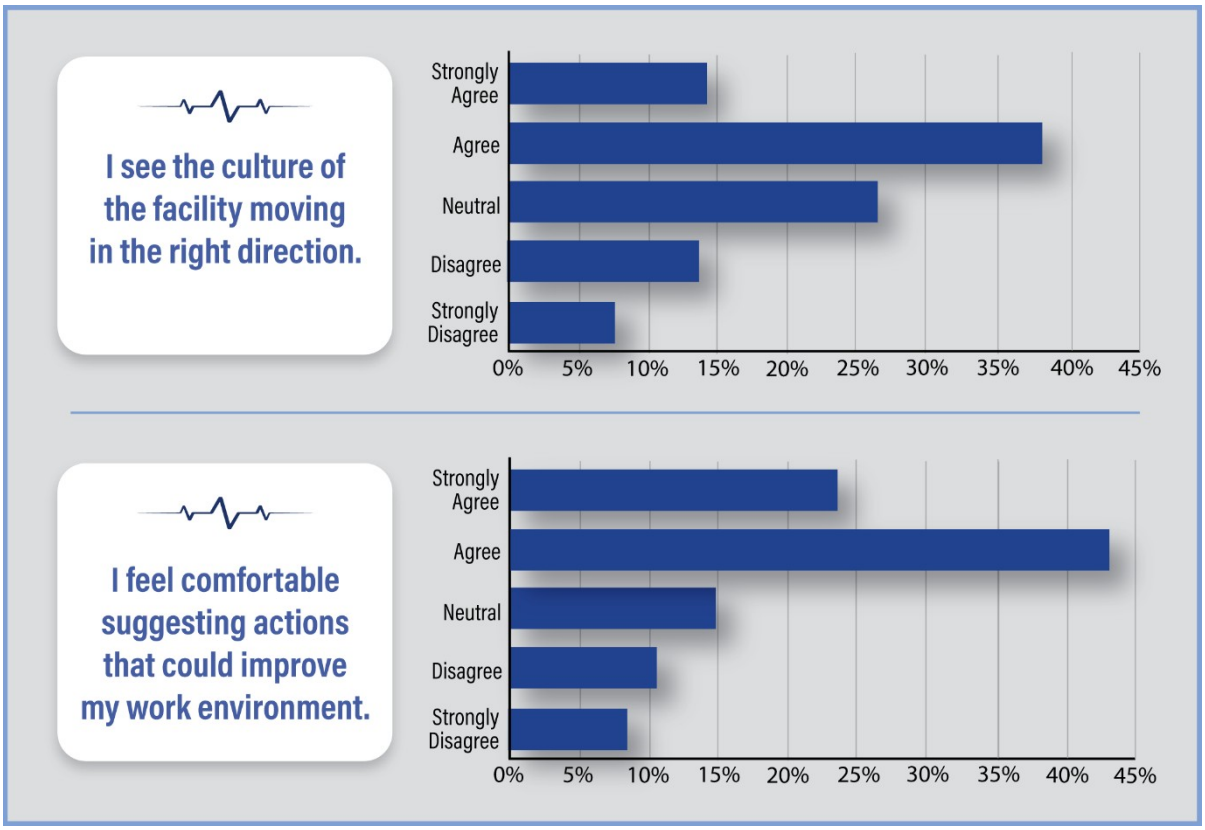


Figure 6. *Employees' perceptions of facility culture.*
Source: OIG questionnaire responses.

The Deputy Chief of Staff stated executive leaders created focus groups to hear from employees on how they could improve psychological safety and their work environment. Executive and facility leaders said these groups helped them develop action plans to improve employee satisfaction, which appeared to be effective because survey scores improved in FY 2023.

[30] An Administrative Investigation Board handles "collecting and analyzing evidence, ascertaining facts and documenting complete and accurate information." VA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

Executive leaders said employees' submission of innovative ideas provided further evidence the facility culture was improving. For example, an employee developed scannable codes on medication bottles to allow veterans to access information on their phone, decrease printing costs, and increase efficiency. The facility entered this project into VHA's Spark-Seed-Spread Innovation Investment Program, which led to five additional VHA facilities using the codes.[31] Additionally, an executive leader explained that employees developed a Compassion Corps, whose role was to make weekly contact with veterans who had reported loneliness or changes in their lives. The leader said employees presented this initiative nationally, and other VHA facilities had started to adopt the concept.

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 VSO questionnaires to understand veterans' experiences with the facility.

In response to an OIG questionnaire, patient advocates named referrals to care in the community as one of veterans' top complaints.[34] According to an executive leader, veterans previously called their VA medical team directly for a referral. However, now veterans' calls go to the Veterans Integrated Service Network (VISN) call center instead of their medical team.[35] They indicated this broke the direct communication link veterans had with their medical team and unnecessarily caused confusion. The executive leader discussed working with VISN leaders to resolve the issue.

Additionally, the Chief of Staff stated the facility had a good relationship with local VSOs. Other executive leaders shared examples of staff and VSOs working together at a local university's behavioral health summit and a suicide prevention event.

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[31] VHA's "Speak-Seed-Spread Innovation Investment Program seeks to identify and accelerate employee-inspired innovations that improve health experiences for Veterans, families, caregivers, and employees." "Spark-Seed-Spread," VHA Innovation Ecosystem, accessed October 7, 2024, https://www.innovation.va.gov/spark-seed-spread.

[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.

[34] "Veterans may be eligible to receive care from a community provider when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed January 22, 2025, https://www.va.gov/CommunityCare.

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

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.[36] 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.[37] 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.[38]

[36] VHA Directive 1608(1).

[37] 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.

[38] 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.

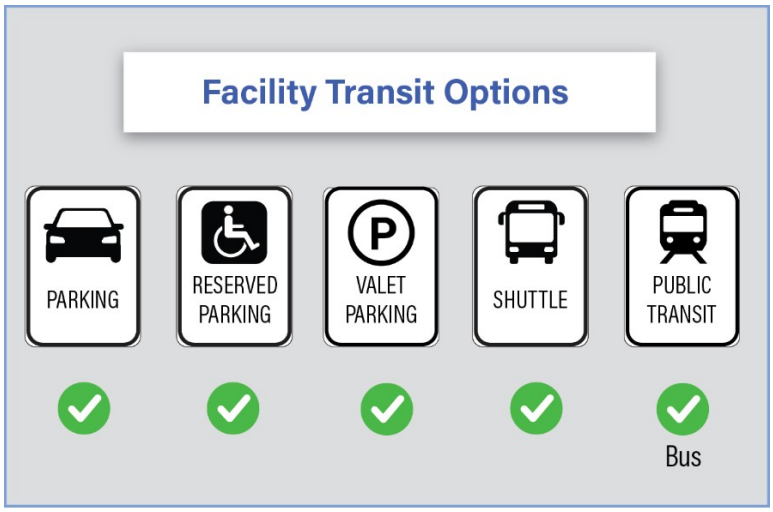

Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG team used the navigation hyperlink located on the facility's website to obtain directions to the site, and signs provided clear directions to the parking areas. The OIG determined the facility had sufficient parking, including accessible spaces for those with disabilities. While there were no emergency call buttons in the parking areas, the OIG found posted signs with a phone number to call for assistance. The OIG also noted the use of golf carts to transport patients to and from the parking lots, as well as a public bus stop located near the main entrance. Based on these observations, the OIG found the facility's transit and parking to be adequate.

Main Entrance

Figure 9. *Facility front entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[39]

The OIG identified the main entrance using signs from the parking lots. The single-level entrance area had valet service and a passenger loading zone. The OIG entered the facility through power-assisted doors and a weapons detection system staffed by at least two VA police officers. Once inside, the OIG noted a volunteer-staffed information desk, available wheelchairs, and a concession stand to purchase snacks and drinks. The OIG also observed seats close to the lobby and

[39] 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*.

additional seating in a nearby open atrium, which had a raised ceiling and large windows for natural light. Overall, the OIG found the entrance to be safe and welcoming.

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.[40]

The OIG noted that while there were no maps at the information desk, volunteers readily assisted veterans either by directing or escorting them to their appointments. The OIG observed signs throughout the facility and successfully used them to navigate the site.

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[41] The OIG found no related complaints to the patient advocate's office. During physical inspections, the OIG observed wheelchairs at the main entrance, as well as large-print signs throughout the facility and braille text adjacent to each elevator.

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

[41] 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.

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.[42]

The lead navigator said the facility had two toxic exposure screening navigators. The lead navigator explained that staff screen most veterans during their primary care appointments or via telephone. As a result, veterans did not experience long wait times for screenings. The lead navigator also discussed outreach activities held in the community to promote screenings, and the OIG observed flyers with screening information and resources by the information desk.

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

The OIG reviewed the facility's most recent OIG comprehensive healthcare inspection report and found no environment of care recommendations.[44] The OIG noted the facility met VHA's goal for staff to close environment of care deficiencies within 14 business days, and an executive leader and a core environment of care team member to attend inspections 90 percent of the time.[45] The OIG also noted that facility leaders tracked action plans until staff resolved the deficiencies. The Chief, Industrial Hygiene and Safety said expired supplies and unsecured protected health and personally identifiable information were common findings. Further, the Chief shared the facility's action plans had been effective in mitigating the issues. The OIG did not find these deficiencies during the physical inspection, which validated the effectiveness of their action plans.

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[42] 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.

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

[44] VA OIG, *Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio*, Report No. 19-00051-40, December 18, 2019.

[45] Assistant Under Secretary for Health for Support (19), "Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024.

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 the outpatient settings focused on safety, cleanliness, infection prevention, and privacy.

VHA requires all medical facilities to provide a "safe, clean and high-quality environment."[46] In addition, The Joint Commission requires hospital staff to maintain a safe environment, making sure "interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided."[47] The OIG inspected two primary care clinics and the urgent care center and found dirty floors, walls with holes left by removed screws, and peeled and scratched paint. Walls that are not intact cannot be properly cleaned, and lack of cleanliness increases the potential spread of infection. The OIG recommends facility leaders ensure Environmental Management Services staff keep patient areas clean and walls intact to minimize the spread of infection.[48]

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.[49] 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.[50] 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.

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[46] VHA Directive 1608(1).

[47] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, EP 1, August 1, 2024.

[48] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

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

[50] 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.

The facility had established processes for informing ordering providers about abnormal test results and following up on the results with patients. Additionally, the facility had a committee that identified opportunities for improvement regarding provider and patient notifications and educated staff at meetings.

Action Plan Implementation and Sustainability

Figure 11. *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.[51] 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 found no open recommendations from the previously published oversight report. Facility leaders attributed successful action plan implementation and sustainment to close monitoring by the Continuous Readiness Committee. They discussed how the committee uses a compliance dashboard to track adherence to action plans resulting from oversight findings.

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.[52] 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.[53] 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 Quality, Safety, and Innovation said staff audit the communication of test results to patients. Once staff identify an issue, the Patient Safety Manager reports the finding to executive leaders, who then decide how to investigate the problem. In addition, the Assistant Chief of Quality, Safety, and Innovation shares monthly reports that include action plans for continuous learning.

[51] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.
[52] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[53] VHA Directive 1050.01(1).

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[54] 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.[55] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[56] 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 there was one vacant provider position within the 44 primary care teams. Despite vacancies in four registered nurse, two licensed practical nurse, and five administrative associate positions, the OIG did not find increased appointment wait times or delays in care. Facility leaders shared that administrative associate positions had the highest vacancy rate because of competing employers in the area. The Deputy Chief of Staff added that in the past 12 months, leaders held two job fairs and hired staff on-the-spot for hard-to-fill nursing and administrative positions. In addition, to cover for the vacancies and support daily operations, leaders temporarily reassigned staff from one department to another.

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.[57] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[58]

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

[55] 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).

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

[57] "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).

[58] VHA Directive 1406(1).

The OIG found that 7 of the 44 primary care teams were larger than expected.[59] A primary care staff member conveyed that generally, panel sizes and coverage expectations were reasonable. Leaders and staff explained they have providers who assist primary care teams as needed, a walk-in clinic, and Saturday appointment times to ensure patients have timely access to care.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[60] 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. While primary staff talked about the process improvement projects, they also shared challenges with the VISN call center. Primary care staff identified issues with VISN call center staff mishandling appointments. For example, call center staff schedule some veterans' appointments with the wrong providers and send messages to the wrong recipients, which delay primary care staff in returning veterans' phone calls. Staff elevated the concern to executive leaders; however, at the time of the inspection, they had not resolved the issue. The OIG suggests facility and VISN leaders collaborate to resolve the call center issues.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The Chief of Staff reported creating two new primary care teams in the last year to prepare for new enrollments following PACT Act implementation. According to a facility leader, primary care teams experienced a 4.75 percent increase in enrollment during FY 2024. An executive leader and a staff member said the increased enrollment did not affect appointment wait times or access to care.

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.

[59] VHA's "baseline capacity for a full-time Patient Aligned Care Team (PACT) is 1,200 patients." VHA Directive 1406(1).

[60] VHA Handbook 1101.10(2).

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.[61]

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).[62] 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."[63] The program did not meet the target in FYs 2021 through 2023; however, it exceeded the target in FY 2024.[64]

The Community Outreach Division Director voiced concerns about the accuracy of the point-in-time count because staff conducting the count did not locate all unsheltered veterans.[65] In an OIG interview, a program staff member added that one of the large, privately funded shelters did not participate in the recent count, which further contributed to an inaccuracy.

Based on a document and interview, the OIG learned the HCHV program consisted of 15 full-time employees and served veterans in 1 urban and 13 rural counties. The division director attributed the FY 2024 improvement to adding two staff members—an eligibility and referral specialist and an outreach staff member for rural counties. The division director said the additional staff in the rural community increased the number of homeless veterans staff identified for enrollment and streamlined the process.

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

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

[63] 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.

[64] The HCHV5 target is 100 percent by the end of the FY. The facility was at 66.04 percent in FY 2021, 49.53 percent in FY 2022, 47.17 percent in FY 2023, and 164 percent in FY 2024, through quarter three. The facility program had to conduct 100 intake assessments in FY 2024 to meet the 100 percent goal, and staff performed more than 100, thereby achieving a score over 100 percent.

[65] The facility's homeless programs comprised the Community Outreach Division, which was situated in the behavioral health department.

The division director discussed working with community partners to establish and maintain various lists of all homeless veterans in the service area. For example, in Franklin County, program staff received a coordinated entry list daily.[66]

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).[67]

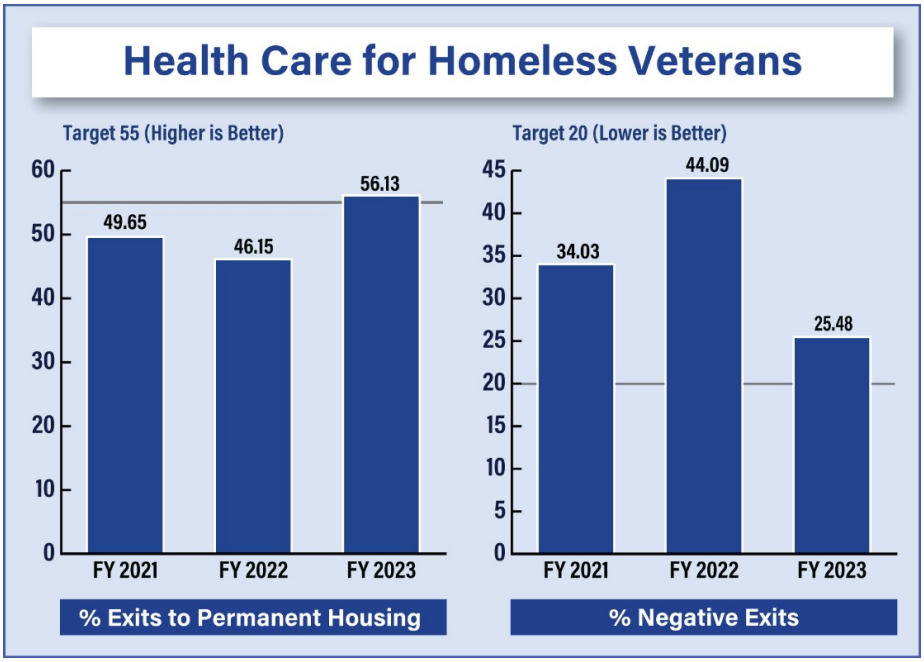

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

Despite missing targets in previous years, the program met them for HCHV1 in FY 2023 and FY 2024 through quarter three, as well as for HCHV2 in FY 2024 through quarter three.[68] The

[66] "The CE [coordinated entry] process is a vital part of ending homelessness among Veterans. CE leverages cooperation between local homeless agencies and service providers to create a robust crisis response system." "VA Homeless Programs: How Coordinated Entry Serves Veterans Experiencing or at Risk of Homelessness," Department of Veterans Affairs, accessed October 23, 2024, https://www.va.gov/how-coordinated-entry. In an interview, the Community Outreach Division Director explained the coordinated entry list ensured program staff were aware of homeless veterans in need of shelter.

[67] 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*.

[68] The facility's HCHV1 FY 2024 through quarter three measure was 61.54 percent and HCHV 2 FY 2024 through quarter three measure was 20.34 percent.

division director attributed the improvement to building a strong relationship with Supportive Services for Veteran Families to provide resources for housing.[69] The division director said staff collaborate with Supportive Services for Veteran Families to provide

- financial assistance for rent deposits,
- incentive money to landlords, and
- increased engagement and presence in shelters.

Although the facility added staff to the Community Outreach Division, the division director emphasized recruitment and retention of staff as a barrier across the homeless programs; in fact, the OIG noted a 28 percent staff vacancy rate in the division. To address this challenge, leaders implemented multiple recruitment strategies like employing student interns, using social worker networks to advertise positions, and posting continuous job announcements. The Chief of Behavioral Health added that leaders were considering bonuses and special salary rates to improve retention.

Community Outreach Division Director discussed homeless veterans' distrust of the VA and government systems, low availability and high cost of housing, and increasing evictions after pandemic funding ended.[70] Specifically, the division director highlighted New Albany, Ohio, where housing was destroyed at development sites, while rental costs increased, which reduced the availability of low-income housing. The division director shared another concern regarding a recent law that restricted camping on public property, causing fear of fines and arrests among homeless individuals.[71] In response to veterans' concerns, program staff said they collaborated with local agencies to secure additional resources and housing.

In addition, the Chief of Behavioral Health said the Oracle electronic health record system posed challenges for the homeless programs. The chief reported the system's workflow process was cumbersome and lacked functionality to capture staff productivity, document all relevant information, and perform other essential database functions. Program leaders highlighted that staff created an Oracle ticket that elevated these concerns to the national homeless program

[69] The Supportive Services for Veteran Families "provides case management and supportive services to prevent the imminent loss of a Veteran's home or identify a new, more suitable housing situation." "Supportive Services for Veteran Families," Department of Veterans Affairs, accessed April 29, 2025, https://www.va.gov/homeless.

[70] The Community Outreach Division Director told the OIG that pandemic aid funds issued between 2020 and 2022 expired after two years.

[71] "On June 28, 2024, the U.S. Supreme Court ruled 6-3 that people experiencing homelessness can be arrested and fined for sleeping outside, even when they have nowhere else to go. Johnson v. Grants Pass overruled lower courts that had determined punishing someone for the status of being homeless violates the U.S. Constitution's ban on cruel and unusual punishment." "U.S. Supreme Court Ruling on Grants Pass v. Johnson," Coalition on Homelessness and Housing in Ohio, accessed April 29, 2025, https://cohhio.org-grants-pass-v-johnson.

office, and they continue to await a response. Despite these challenges, program leaders and staff maximized their resources to meet veterans' needs and build trust.

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."[72] 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.[73]

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).[74] The program met the target in FY 2021. A program staff member described working with four public housing authorities. The program staff member stated that staffing shortages limited the number of veterans housed in FYs 2022 and 2023. Despite this challenge, the OIG reviewed documentation that showed the program only narrowly missed targets during those years.[75]

VHA requires facility leaders to ensure there are enough qualified staff to safely and effectively deliver services to veterans in the program.[76] At the time of the site visit, the OIG noted a 30 percent program staff vacancy rate, including the deputy director position, and staff reported burnout and emotional stress. The Chief of Behavioral Health reported ongoing recruitment efforts and offering hiring incentives to fill the vacancies. The OIG recommends the Medical Center Director evaluates the allocation of resources to ensure the Housing and Urban

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

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

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

[75] The facility's HMLS3 scores were 93.37 percent for FY 2021 (the target was 92 percent); 87.53 percent for FY 2022 (the target was 90 percent); and 88.01 percent for FY 2023 (the target was 90 percent).

[76] VHA Directive 1162.05(2), *Housing and Urban Development of Veterans Affairs Supportive Housing Program*, June 29, 2017, amended June 24, 2024.

Development–Veterans Affairs Supportive Housing program meets the needs of the veterans served.[77]

In an interview, program staff stated they identify veterans through contacts with national and local homeless hotlines, homeless shelters, and facility outreach staff. They also prioritize veterans in need of housing and meet weekly with Supportive Services for Veteran Families to identify potential enrollees. The OIG reviewed documents and found evidence of how program staff analyzed risk factors, such as advanced age, substance abuse, mental health issues, and low income, to prioritize the most vulnerable veterans for housing.

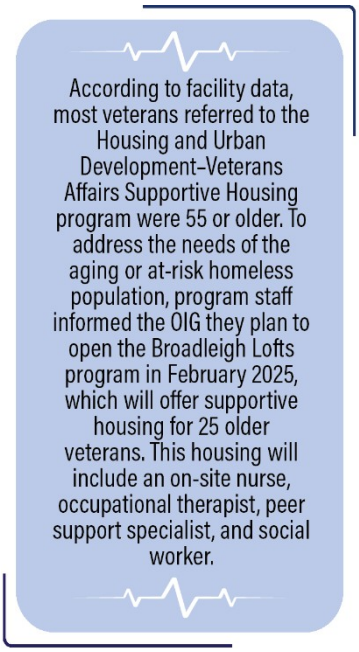

Figure 13. *Supportive housing project.*
Source: OIG interviews and review of documents.

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).[78] From FY 2021 through FY 2023, the facility only met the target in FY 2022.[79] The Chief of Behavioral Health reported that due to staff vacancies, the facility could not offer all support services usually provided under the Compensated Work Therapy program.[80] As a result, they did not anticipate meeting the target by the end of FY 2024 either.

Program staff identified substance abuse disorder treatment and care for severe behavioral health issues as the top two needs of veterans referred to the program. For veterans needing this care, program staff perform clinical assessments and refer them to mental health outpatient care, specialized treatment programs, and a psychiatrist when necessary.

[77] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

[78] 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*.

[79] The facility's VASH 3 scores were 42.9 percent in FY 2021 (target was 45.0 percent), 51.0 percent for FY 2022 (target was 47.0 percent), 46.9 percent for FY 2023 (target was 50.0 percent), and 39.6 percent for FY 2024 through quarter 3 (end of FY target was 50.0 percent).

[80] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers." "Veterans Health Administration, Compensated Work Therapy," Department of Veterans Affairs, accessed October 21, 2024, https://www.va.gov/health/cwt/.

Program staff reported strong relationships with community partners for financial assistance with security deposits, rent, and tangible resources such as furniture. Program staff also serve as authorized representatives of the Franklin County Department of Jobs and Family Services to assist veterans with applications for resources and services.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[81] 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.[82]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[83] The program did not meet the target for FY 2023 but did for FY 2024 through quarter three.[84] Program staff attributed missing the target to their misunderstanding of enrollment requirements. For example, they believed they had to meet with a veteran three times prior to enrollment. Once staff understood there was no requirement to meet that often, they enrolled more veterans into the program.

> The facility established a memorandum of understanding with Franklin County municipal court, which "links veterans with appropriate treatment providers and requires frequent contact with the judge to maintain accountability, reduce recidivism, and increase public safety." The agreement required program staff to attend weekly treatment meetings and provide written progress reports.

Figure 14. *Franklin County municipal court.*
Source: Memorandum.

The OIG reviewed documents and learned the program consisted of four coordinators who serve 13 jails, 5 prisons, and 4 veterans treatment courts in 14 counties.[85] The OIG reviewed documentation from October 2022 through August 2024 that showed program staff participated in 192 community outreach and educational events for facility staff, local law enforcement, court staff, VSOs, and community organizations. For example, program staff said they educated the facility's primary care social workers on how to refer veterans to the program; this resulted in

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

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

[83] 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*.

[84] The facility's performance metric was 98 percent in FY 2023 and 98 percent in FY 2024 through quarter three.

[85] 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.

improved collaboration between the staff and increased enrollments. In addition, a program staff member described using the Veteran Re-Entry Search Service system to identify incarcerated veterans and enroll them in the program.[86]

Meeting Veteran Needs

Program staff said they built strong partnerships with VA police and other law enforcement divisions to focus on deflection initiatives, which prevent incarceration by connecting veterans to mental health and recovery services.[87] For example, staff partnered with the Veteran Mobile Evaluation Team, which included a clinical psychologist, VA police, local police, and social workers; this team responds quickly to incidents involving veterans who may be experiencing a mental health crisis or needing a wellness check.

During an interview, staff identified barriers to meeting the needs of veterans who will soon be released from incarceration and transferred to mental health residential treatment programs, including issues with appointment scheduling, limited public transportation, and COVID-19 testing requirements. To schedule a facility medical appointment, staff said VA requires the veteran be present or on the phone. Due to limited phone access in the jail, this posed a challenge for soon-to-be-released veterans, and could delay care. To address the issue, staff partnered with facility volunteers to provide prepaid calling cards to incarcerated veterans who were otherwise unable to contact VA staff.

Program staff reported challenges such as limited public transportation in the service area, so they helped veterans get from jail or prison to mental health residential treatment programs. In addition, the programs required laboratory-confirmed negative COVID tests for admission, which jails did not perform. Consequently, staff spent additional time transporting veterans to the facility for required testing and then to the treatment program location. Staff overcame the barriers and built strong community and VA partnerships.

[86] "The Veterans Re-Entry Search Service (VRSS) is an automated system used to identify Veterans who are incarcerated or under supervision in the courts. VA does not have enough resources to personally contact all identified incarcerated Veterans, so correctional facility staff can assist with referrals to Veteran services." Department of Veterans Affairs, *Veterans Re-Entry Search Service (VRSS) Veterans Health Administration (VHA) VA Homeless Program Office*, October 1, 2022.

[87] A deflection team is a "multidisciplinary group [that] serves as a bridge between first responders and the VA by facilitating timely notifications about Veterans that could benefit from mental health support, substance abuse treatment, or assistance navigating the justice system." Department of Veterans Affairs," JAHVH [James A. Haley Veterans' Hospital] Deflection Team and Tampa First Responders Partner to Help Veterans," https://www.va.gov/tampa-health-care/deflection-team-and-tampa-first-responders-partner-to-help-veterans/.

Conclusion

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

OIG Recommendations and VA Response

Recommendation 1

Facility leaders implement a standardized process for service-level communication to consistently disseminate information.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility concurs with the recommendation. To address the identified finding, the following actions have been implemented and are ongoing under the guidance of the Medical Center Director and High Reliability Organization (HRO) Lead:

1. A Microsoft TEAMS Channel "HRO in the Know" to provide resources and High Reliability Organization (HRO) education that is accessible to all facility staff was created October 31, 2024.
2. Between FY 24 to date, 54 Huddle Boards were deployed across organizational departments. Currently, a total of 86 virtual Huddle Boards are active and in use.
3. Collaboration with the facility's Webmaster was initiated October 7, 2024, to create a robust Tiered Huddle System, which is currently in testing phase.
4. Regular, scheduled Executive Leadership Team and HRO Coordinator in person rounding to services began November 27, 2024, and is ongoing.
5. HRO updates and resources communicated within the facility's local "Wylie Express" Newsletter began December 1, 2023, and is ongoing.
6. Bi-weekly HRO education and updates are provided during Friday Morning by the HRO Coordinator or the HRO Lead. This was originally performed monthly, but was increased to bi-weekly beginning November 26, 2024, and remains ongoing at that cadence.
7. Monthly HRO/Patient Safety Forums are open to all staff, with sessions recorded for later viewing began October 26, 2023, and are ongoing.
8. Inclusion of both clinical and non-clinical Front-Line Staff in the facility's HRO Committee to serve as representatives began April 10, 2024, and is ongoing.
9. Distribution of Tired Huddle and Service Level Rounding education and reference materials provided to all Service Chiefs during Morning Report presentations and

HRO/Patient Safety Forums began May 26 - 28, 2025 and are ongoing with identified services as needed.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

Facility leaders ensure Environmental Management Services staff keep patient areas clean and walls intact to minimize the spread of infection.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility concurs with the recommendation. A work order for the damaged flooring in the Urgent Care Center, rooms 1, 2 and 11, was submitted and completed with replacement of the vinyl flooring on February 25, 2025. The identified damaged wall in the Primary Care Service's Women's Health patient care room 3A306 was repaired on April 4, 2025.

The Associate Director is responsible for identification of contributing factors, implementation and sustainment of corrective actions to address the identified findings. Analysis revealed that due to an increase in staff resignations within the Environmental Services (EVS) department in FY24, floors were not being polished as frequently as needed. Facility leadership authorized overtime for EVS staff to ensure routine floor cleaning is performed regularly. Additionally, ongoing recruitment incentives have been authorized to support recruitment for vacant positions within the department. The Facility requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

The Medical Center Director evaluates the allocation of resources to ensure the Housing and Urban Development–Veterans Affairs Supportive Housing program meets the needs of the veterans served.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility concurs with the recommendation. The Associate Director is responsible for implementation and sustainment of these corrective actions to address the identified finding. At the time of the Inspection, the facility had a 30% vacancy rate. The facility has and will continue to pursue active recruitment to fill the remaining vacancies. In addition, a Special Salary Rate (SSR) reevaluation was requested to assist with recruitment and retention rates with the Housing and Urban Development–Veterans Affairs Supportive Housing (HUDVASH) program. To date, the vacancy rate has been reduced. Staffing for the HUDVASH Program is currently 90.24%, which is above the national goal of 90%. The facility requests closure of this recommendation.

OIG Comments

The OIG considers this recommendation closed.

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 26 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 September 24 through 26, 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 distributed questionnaires to 26 VSOs identified by the facility, and 3 responded.

[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).*

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: July 11, 2025

From: Acting Network Director, Veterans Integrated Service Network 10 (10N10)

Subj: Healthcare Facility Inspection of the VA Central Ohio Health Care System in Columbus

To: Director, Office of Healthcare Inspections (54HF01)

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

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

(Original signed by:)

Joshua Rawlins
Acting Deputy Network Director
For
Beth Lumia, MSW
Acting Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 10, 2025

From: Director, VA Central Ohio Health Care System (757)

Subj: Healthcare Facility Inspection of the VA Central Ohio Health Care System in Columbus

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

1. Thank you for the opportunity to review and comment on the draft report of the OIG Healthcare Facility Inspection of the VA Central Ohio Healthcare System in Columbus, Ohio. I wish to further extend my gratitude to the OIG and to the Healthcare Facility Inspection team for the collaboration during the inspection and for the professional review of the organization.
2. Corrective action plans have been developed and implemented. We appreciate the opportunity to continually grow as a High Reliability Organization with a commitment to quality improvement.
3. I would like to respectfully request closure of recommendations 1, 2 and 3 as we have successfully completed the necessary corrective actions.
4. Any comments or questions regarding the content of this memorandum may be directed to the organization's Chief of Quality, Safety, and Innovation.

   The insights and recommendations outlined in the report are greatly appreciated and will guide us as we continue to seek opportunities to continually improve our practices and operations which is essential in our mission to provide exceptional care to our Veterans.

   (Original signed by:)

   Marc Cooperman M.D.
   Medical Center Director

OIG Contact and Staff Acknowledgments

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