US DEPARTMENT OF VETERANS AFFAIRS
**OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the VA Detroit Healthcare System in Michigan

| Healthcare Facility Inspection | 24-00607-241 | October 17, 2025 |
|---|---|---|


## OUR MISSION

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

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# Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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

## What the OIG Found

The OIG physically inspected the VA Detroit Healthcare System (facility) from August 20 through 22, 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. Staff identified leadership turnover as a system shock. In 2021, VHA's Office of the Medical Inspector investigated the facility's surgery service and issued recommendations related to executive leaders' oversight of patient safety issues, and employees' fear of reprisal for reporting safety concerns.[2] Following the investigation, the Veterans Integrated Service Network Director removed members of the executive team, except

[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] "The Office of the Medical Inspector independently investigates health care issues raised by Veterans and other stakeholders to monitor and improve the quality of care provided by VHA." "Veterans Health Administration, VHA Office of the Medical Inspector," Department of Veterans Affairs, accessed January 30, 2025, https://www.va.gov/health/medicalinspector. Department of Veterans Affairs, *Report to the Under Secretary for Health, John D. Dingell Veterans Affairs Medical Center, Detroit, Michigan*, TRIM 2021-C-51, April 16, 2022. (This report is not publicly accessible.) VA OIG, *Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan*, Report No. 22-04099-153, July 18, 2023.

for the Associate Director, and assigned interim leaders until hiring permanent ones in 2023.[3] The current executive leadership team had been in place about one year.

Executive leaders said they use different forums to communicate with employees, such as during virtual daily morning meetings. They also shared that they implemented an "open mic" at town halls so employees can ask questions and an anonymous suggestion box to solicit ideas.

Finally, the OIG found that veterans had opportunities to communicate concerns and feedback to leaders through veterans service organizations and the patient advocates.[4] The OIG determined staff tracked veterans' concerns until they were resolved.

## 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 observed ample parking and a city bus stop in front of the facility. The facility had three main entrances, and the OIG found them all to be clean and well-lit. However, the OIG noticed torn furnishings in one of the lobbies, which may prevent staff from effectively cleaning the surfaces, and made an associated recommendation. In response to the recommendation, the Director reported staff expect to replace the damaged furniture in October 2025.

Additionally, the OIG found that information desk staff at all three entrances did not have maps available to help veterans navigate the facility and could not identify resources to assist those with sensory (hearing and vision) impairments. The OIG made a recommendation related to staff having maps available. Prior to publication of this report, staff implemented corrective actions, and the OIG closed this recommendation.

The OIG also noted that veterans with sensory impairments might have difficulties viewing the small font on the facility's navigation application and lobby directory. Facility staff had already identified the need to improve navigation aids and executive leaders had tasked the Interior Designer with creating a proposal to improve navigation cues. The designer had completed the

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

[4] Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf. Patient 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/.

proposal and submitted it to executive leaders, and therefore, the OIG did not make a recommendation.

Additionally, the OIG noted there was no information about toxic exposure screenings at the facility entrances.[5] Executive leaders should ensure staff make this information available to veterans.

The OIG also observed equipment marked as clean stored in an Emergency Department restroom that was used by patients. Nursing staff reported the area lacked adequate clean storage rooms, so they stored the equipment where it would not obstruct pathways. The OIG also noted equipment that obstructed an unoccupied patient room in the Intensive Care Unit, and equipment labeled as defective stored in the Medical Surgical Unit's clean supply room. Nursing staff were unable to explain why the defective equipment had not been picked up for repair. The OIG made recommendations for staff to resolve these safety and infection risks. The Director responded to the recommendation and reported that staff relocated clean equipment to a designated clean storage room, and staff started monitoring storage areas, checking for defective equipment, and ensuring hallways are free from obstructions.

The OIG also found staff did not adequately protect personally identifiable information on nurses' computer screens in some patient care areas. The OIG made a recommendation for staff to address patients' privacy, and the Director said the Chief of Logistics ordered additional privacy screens for the computers.

## Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The facility had one open recommendation from previous oversight reviews.

The patient safety managers said they had 85 overdue actions from root cause analyses in November 2023.[6] The Chief of Staff attributed the delays in completing actions to previously having one patient safety manager. However, at the time of the inspection in August 2024, the facility had three patient safety managers. The patient safety managers said staff responsible for completing some of the actions no longer worked at the facility, but they were working with current staff to complete the overdue actions, which have decreased to 6 open longer than a year.

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

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

## 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.[7]

The OIG noted most primary care team vacancies in the past 12 months were for licensed practical nurse positions, and there were currently only four such vacancies in August 2024. Primary care leaders attributed the vacancies to VA pay for licensed practical nurses being lower than community facilities but said retention had improved after leaders increased pay.

Wait times for primary care appointments ranged from four to six days for established patients and four to nine days for new patients. Staff described patient panel sizes (the number of patients assigned to each team) as manageable and attributed short wait times to the availability of medical support staff for scheduling patient appointments. Additionally, staff reported reviewing upcoming schedules to determine if patients' needs warranted an appointment or if their concern could be addressed through a phone call, such as for medication refills. The OIG found that primary care staff initiated several process improvement projects, such as an immunization clinic staffed by registered nurses that decreased the number of unscheduled clinic visits, and leaders were responsive and supportive of the efforts.

Finally, the OIG reviewed veteran enrollment data from fiscal years 2021 through 2023 and found it had declined. Primary care leaders reported more veterans were now located outside the Detroit metro area, so executive leaders opened a community-based outpatient clinic in Trenton, Michigan and plan to open another in Macomb County.

## Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found that homeless program staff successfully met their performance metric to move veterans into permanent housing in fiscal year 2023. Homeless program staff shared examples of participating in multiple activities in the community to reach veterans and collaborating with community partners to provide essential services, such as food, shelter, and legal services. Staff shared that outreach efforts go beyond providing information about homeless resources, they also connect veterans with a broader range of VA services, including primary and dental care.

The Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet its performance target for securing housing for veterans for fiscal year 2023. Program staff

[7] PACT Act.

stated that barriers such as past evictions and criminal records may increase the time it takes to secure housing.

## What the OIG Recommended

The OIG made six recommendations.

1. Executive leaders ensure staff fix or replace damaged furnishings to allow effective cleaning and disinfection.
2. Executive leaders ensure staff place paper maps at information desks to assist veterans in navigating the facility.
3. Executive leaders ensure staff store clean equipment in a sanitary environment.
4. Executive leaders ensure hallways and exits are free from obstruction.
5. Executive leaders ensure staff remove defective equipment from clinical areas to prevent use.
6. Executive leaders ensure staff have computer screen privacy filters to protect patients' personally identifiable information.

## VA Comments and OIG Response

The acting Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans and leaders are implementing corrective actions (see OIG Recommendations and VA Response). Based on information provided, the OIG considers recommendation 2 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

# Abbreviations

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

# FACILITY IN CONTEXT

**VA Detroit Healthcare System**
**Detroit, Michigan**
Level 1b-High Complexity
Wayne County
Hospital Referral Region: Detroit

## Description of Community

### POPULATION

| | |
|---|---|
| Female **2,131,624** | Male **2,020,924** |
| Veteran Female **17,766** | Veteran Male **175,247** |

Homeless - State **8,206**
Homeless Veteran - State **498**

### MEDIAN INCOME

**$62,004**

### EDUCATION

**91%** Completed High School
**63%** Some College

### VIOLENT CRIME

Reported Offenses per 100,000 **278**

### SUBSTANCE USE

**23.6%** Driving Deaths Involving Alcohol
**21.1%** Excessive Drinking
**1,379** Drug Overdose Deaths

### UNEMPLOYMENT RATE

**6%** Unemployed Rate 16+
**4%** Veterans Unemployed in Civilian Workforce

### TRANSPORTATION

| | |
|---|---|
| Drive Alone | 1,555,407 |
| Carpool | 157,602 |
| Work at Home | 118,273 |
| Walk to Work | 27,247 |
| Public Transportation | 26,168 |
| Other Means | 23,858 |

### AVERAGE DRIVE TO CLOSEST VA

| | |
|---|---|
| Primary Care | **25.5 Minutes, 21.5 Miles** |
| Specialty Care | **42.5 Minutes, 40 Miles** |
| Tertiary Care | **68.5 Minutes, 70 Miles** |

## Access to Health Care

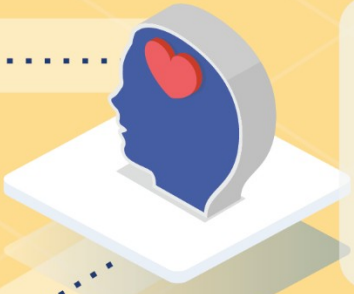
### ACCESS

VA Medical Center Telehealth Patients **16,457**

| | |
|---|---|
| Veterans Receiving Telehealth (VHA) | 41% |
| Veterans Receiving Telehealth (Facility) | 40% |
| <65 without Health Insurance | 11% |

# Health of the Veteran Population

**230** VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

**10,151**

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

**4.66** Days

30-DAY READMISSION RATE

**11%**

## SUICIDE RATE PER 100,000

| Suicide Rate (state level) | Veteran Suicide Rate (state level) |
|---|---|
| 18 | 31 |

# Health of the Facility

## UNIQUE PATIENTS

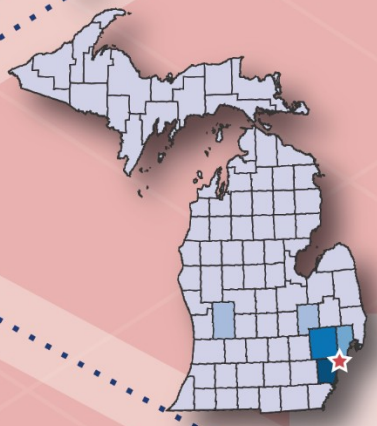
| | |
|---|---|
| Unique Patients VA and Non-VA Care | 46K |
| Unique Patients VA Care | 44K |
| Unique Patients Non-VA Care | 12K |

## COMMUNITY CARE COSTS

| | |
|---|---|
| Unique Patient $20,895 | Outpatient Visit $277 |
| Line Item $770 | Bed Day of Care $243 |

## STAFF RETENTION

| | |
|---|---|
| Onboard Employees Stay <1 Yr | 16.92% |
| Facility Total Loss Rate | 11.00% |
| Facility Retire Rate | 2.27% |
| Facility Quit Rate | 7.41% |
| Facility Termination Rate | 1.23% |



★ VA MEDICAL CENTER

VETERAN POPULATION

0.04% 3.08% 6.11% 9.15% 12.18% 15.20%

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

# Contents

# Background and Vision

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

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


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

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

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

## High Reliability Organization Framework

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

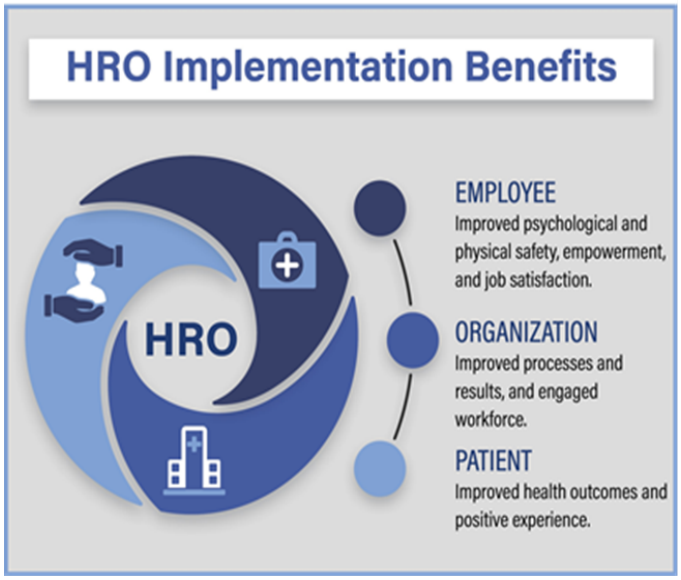



***Figure 2.*** *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG inspectors observed how facility leaders incorporated high reliability principles into their operations.

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

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

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

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

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

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

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

## PACT Act

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

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

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

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

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

# Content Domains


***Figure 3.*** *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
*Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.*

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

The VA Detroit Healthcare System (facility) is comprised of the John D. Dingell VA Medical Center and four outpatient clinics. The facility opened in 1939 as a Veterans Administration hospital, and it currently provides care to approximately 350,000 veterans in Wayne, Oakland, Macomb, and St. Clair counties in Michigan. The facility has 264 hospital beds, including a 50-bed Mental Health Residential Rehabilitation Treatment Program. In November 2024, the Fisher House Michigan opened, providing a place for families to stay free of charge while veterans are hospitalized.[13] The facility had a fiscal year (FY) 2023 budget of $586,432,591.

The facility's executive leaders consisted of the Medical Center Director (Director), appointed in August 2023; Associate Director of Patient Care Services/Nurse Executive, assigned in November 2023; Associate Director, appointed in April 2017; Assistant Director, assigned in July 2023; and the Chief of Staff, who had served as the Deputy Chief of Staff since April 2011 and started in the current role in November 2023.


A 2018 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] "What is a Fisher House?," Fisher House Michigan, accessed October 30, 2024, https://www.fisherhousemichigan.org.

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

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

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

## System Shocks

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

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. Staff identified turnover in key leadership positions as a system shock. VHA's Office of the Medical Inspector published a report that highlighted a lack of executive leaders' actions in responding to patient safety concerns in the surgery service that staff had reported, and staff's fear of reprisal if they reported safety concerns.[19] In response to the investigation, the Veterans Integrated Service Network (VISN) Director changed executive leaders at the facility, except for the Associate Director, and assigned interim leaders beginning in 2021, until hiring permanent ones in 2023.[20] At the time of the inspection in August 2024, the executive leadership team had worked together in their current roles for about one year.

Executive leaders said staff were exhausted following challenges with the prior leadership team and they wanted to create an environment of psychological safety and trust between leaders and staff.[21] Leaders discussed the changes they made to improve the facility's culture following the investigation. For example, they believed prior leaders had not taken staff's concerns seriously, so they now investigate all complaints. Leaders also rearranged the reporting structure to ensure they receive pertinent information.

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

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

[19] "The Office of the Medical Inspector independently investigates health care issues raised by Veterans and other stakeholders to monitor and improve the quality of care provided by VHA." "Veterans Health Administration, VHA Office of the Medical Inspector," Department of Veterans Affairs, accessed January 30, 2025, https://www.va.gov/health/medicalinspector. Department of Veterans Affairs, *Report to the Under Secretary for Health, John D. Dingell Veterans Affairs Medical Center, Detroit, Michigan*, TRIM 2021-C-51, April 16, 2022. (This report is not publicly accessible.)

[20] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/. VA OIG, *Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit, Michigan*, Report No. 22-04099-153, July 18, 2023.

[21] "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.

## 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] Respondents to the OIG-administered questionnaire described current leaders' communication as clear, useful, and frequent. In an interview, executive leaders said they include all staff in multiple forms of communication. For example, they invite all staff to attend virtual daily morning meetings, which cover topics such as patient safety, quality metrics, kudos, and guided relaxation exercises.

Executive leaders also said they implemented an "open mic" at monthly town halls, where staff can ask leaders questions, as well as an anonymous suggestion box for them to provide feedback, share concerns, and propose ideas. The Director said executive leaders and the Chief, Quality and Patient Safety review suggestion box submissions weekly and assign each item to an executive leader. The assigned leader is then responsible for following up on the suggestion and with the staff member who submitted it. For example, a staff member suggested leaders discuss construction projects at town halls, and leaders said they dedicated the following meeting to that topic.

[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.

## Employee Experience

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

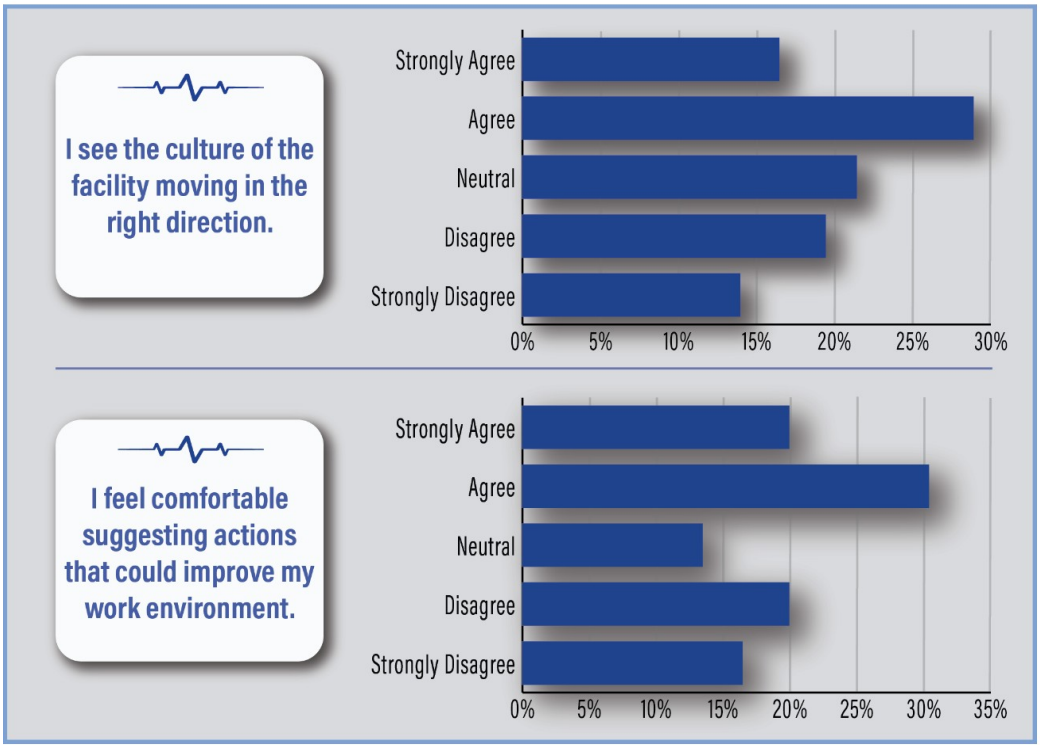


***Figure 4.*** *Employee and leaders' perceptions of facility culture.*
*Source: OIG questionnaire responses.*

One leader stated they share results of the survey with employees and get their feedback on how leaders can support them in doing their job. The leader further explained that this builds employees' confidence and trust in the leaders.

[26] Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout."

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

## Veteran Experience

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

The OIG reviewed a list of veterans' concerns reported to the patient advocates from June 2021 through March 2024. Patient advocates used the list to track the concerns, and staff had resolved most of them. Executive leaders stated they meet with VSOs quarterly, and the Director added that VSOs located at the facility can come directly to their office for any concerns. Additionally, leaders said they regularly direct veterans to VSO offices when they have questions about their eligibility for benefits.

## ENVIRONMENT OF CARE

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

***Figure 5.*** *Photo of the John D. Dingell Medical Center of the VA Detroit Healthcare System in Michigan. Source: "John D. Dingell Department of Veterans Affairs Medical Center," Department of Veterans Affairs, accessed September 26, 2024, https://www.va.gov/detroit-health-care/locations/.*

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

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

[30] VHA Directive 1608(1).

## Entry Touchpoints

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

### 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.

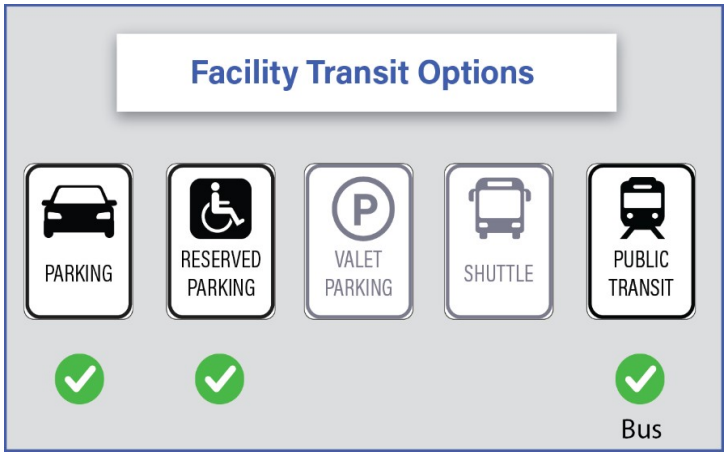


***Figure 6.*** *Transit options for arriving at the facility.*
*Source: OIG analysis of documents and observations.*

The OIG entered the address listed on the facility's public website into a mobile navigation application and arrived without problems. The OIG also observed a public bus stop located in front of the facility that was easily accessible to veterans. The OIG determined the facility had ample parking, including spaces accessible to those with disabilities, and an attached parking garage.

### Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[33] The OIG noted that all three main entrances (labeled as blue, yellow, and red) had passenger loading zones, power-assisted doors for easy access, and

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

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

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

physical assistance devices such as wheelchairs. The entrances were clean, well-lit with natural lighting, and had information desks with staff to greet veterans. The OIG also observed free coffee service and a seating area to provide veterans with a place to socialize.

However, the OIG found the lobby seating in the blue entrance had torn upholstery, which may prevent effective cleaning and disinfection. Joint Commission standards require staff to keep "furnishings and equipment safe and in good repair."[34] The engineering chief stated the Comprehensive Environment of Care Committee planned to replace the furnishings, but executive leaders halted the project's funding due to the overall VA budget. When the OIG asked how leaders planned to resolve the problem, the Associate Director and Chief, Facilities Management Service did not provide a plan to address the issue.

The OIG recommends executive leaders ensure staff fix or replace damaged furnishings to allow effective cleaning and disinfection. The Director responded to the recommendation and reported that staff ordered furniture for the lobby in December 2024 and expect to install it in October 2025 (see OIG Recommendations and VA Response).

## 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.[35]

The OIG found that all three main entrance information desks lacked printed maps to help veterans navigate the facility. The engineering chief said staff would ensure each information desk has maps available, but they were still not available by the last day of the inspection.

The OIG recommends executive leaders ensure staff place paper maps at information desks to assist veterans in navigating the facility. According to the Director's response

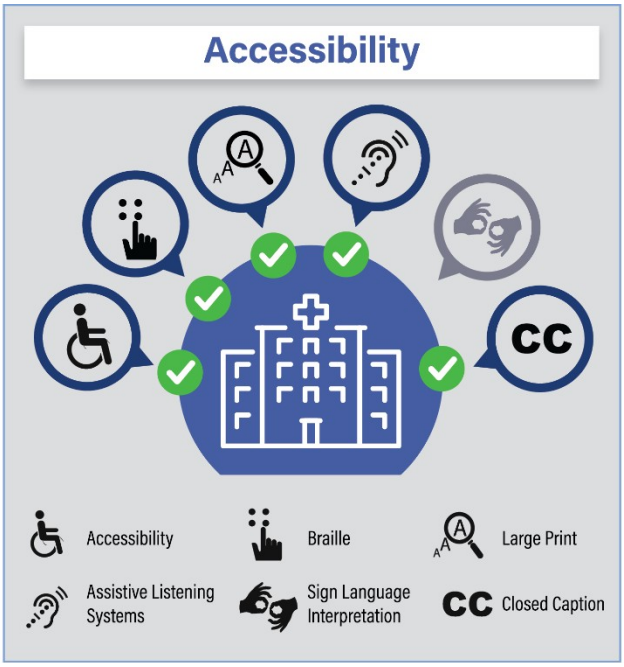


***Figure 7.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: OIG observations.*

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

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

to the recommendation, leaders updated paper maps and they are now available at the information desk for veterans' use. Staff at the information desk also educate veterans on using their personal devices for an interactive electronic map. The OIG considers this recommendation closed (see OIG Recommendations and VA Response).

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] The facility offered veterans an option to download a mobile navigation application. However, the map display was small and could not be enlarged, making it difficult to read. The OIG also noticed a lobby directory with small font size, but signs above hallway intersections had larger font.

Facility staff had already identified a need to improve their navigation aids and collaborated with the University of Michigan to assess opportunities to enhance veterans' experiences. Additionally, the Interior Designer described receiving a task from executive leaders to develop a project proposal to increase the font size on signs and add color coding to differentiate clinic locations, which had been submitted for approval. Therefore, the OIG did not make a recommendation.

The OIG noted braille on exam room doors, audio instructions in the elevators, and closed captioning on some televisions. Although staff at all information desks said they assist patients in getting to their destinations, they were unable to communicate in basic sign language or identify resources to assist veterans with sensory impairments. While the OIG made no recommendation, executive leaders should ensure information desk staff are aware of available resources to help veterans with sensory impairments navigate the facility.

## 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.[37]

The OIG found no information or directions for veterans to locate toxic exposure screening navigators at any of the facility entrances. Additionally, information desk staff did not know where veterans could receive screenings. The OIG reviewed documents that confirmed the facility had at least two navigators, who had no concerns related to the screening process or wait

[36] 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.

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

times. Although the OIG did not make a recommendation about having toxic exposure screening pamphlets at the information desks, executive leaders should add them.

## 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.[38] 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 did not identify any recurring issues.

## General Inspection

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

The OIG observed that, overall, the facility was clean and well-maintained.[39] However, the OIG found multiple pieces of equipment labeled as clean in an Emergency Department bathroom that was used by patients. VHA requires staff to follow infection prevention guidance when storing clean equipment to prevent spread of infection.[40] The Emergency Department Chief Nurse said the unit did not have adequate storage space, so staff placed the items in the bathroom to avoid blocking an exit. The OIG also noted that staff stored multiple equipment items on both sides of the hall leading to a patient room on the Intensive Care Unit. Although the room was unoccupied, the equipment obstructed the path to the room.

The Joint Commission requires exit paths to be clear of obstructions to ensure patients and staff can move safely between areas and leave buildings.[41] Staff in both areas reported a lack of storage space as the reason for the noncompliance.

The OIG recommends executive leaders ensure staff store clean equipment in a sanitary environment. The OIG also recommends executive leaders ensure hallways and exits are free from obstruction. In response to these recommendations, the Director reported that in September

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

[39] The OIG physically inspected five areas: the Medical Surgical and Intensive Care Units, Primary Care Clinic, Emergency Department, and Community Living Center.

[40] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

[41] The Joint Commission, E-dition *Standards Manual*, LS.02.01.20, August 1, 2024.

2025, staff began monitoring clean and dirty storage rooms to ensure equipment and supplies are stored appropriately and checking that hallways are free from obstructions (see OIG Recommendations and VA Response).

The OIG also observed five pieces of equipment in the Medical Surgical Unit's clean supply room labeled as defective, and staff had not removed them. VHA requires staff to remove all products "deemed defective or potentially harmful."[42] When asked, nursing staff on the unit were unable to explain why the equipment had not been removed. Storing defective equipment in a clean supply room may lead to unintentional use and potentially cause harm.

The OIG recommends executive leaders ensure staff remove defective equipment from clinical areas to prevent use. According to the Director, staff began conducting weekly audits in September 2025 to ensure there is no defective equipment in clinical areas (see OIG Recommendations and VA Response).

Additionally, the OIG observed easily visible personally identifiable information on computer screens in the Intensive Care Unit, Medical Surgical Unit, and Primary Care Clinic. The Health Insurance Portability and Accountability Act of 1996 requires healthcare organizations to maintain reasonable and appropriate safeguards to prevent unintentional disclosure of protected health information, which includes personally identifiable information such as names and diagnoses.[43] Nursing leaders on the units acknowledged the privacy concerns and stated staff received new computer screens but no privacy filters.

The OIG recommends executive leaders ensure staff have computer screen privacy filters to protect patients' personally identifiable information. In response, the Director reported that in September 2025, the Chief of Logistics ordered additional privacy screens, and staff audit computer privacy monthly (see OIG Recommendations and VA Response).


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.

[42] VHA Directive 1068, *Removal of Recalled Medical Products, Drugs, and Food from VA Medical Facilities,* June 19, 2020.

[43] Department of Health & Human Services, Office for Civil Rights, *Summary of the HIPAA [Health Insurance Portability and Accountability Act of 1996] Privacy Rule*, May 2003; 45 C.F.R. §§ 160 and 164 (2025).

## 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.[44] 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.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG noted that quality measure scores reflecting providers' timely communication of abnormal test results to patients had improved in the fourth quarter of FY 2023 and first quarter of FY 2024. The Chief of Staff attributed their performance to leaders monitoring provider's compliance as part of their Ongoing Professional Practice Evaluations.[46] The chief also said leaders reeducate providers on expectations for test result communication when needed.

## Action Plan Implementation and Sustainability


***Figure 8.*** *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.[47] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG noted the previous 2021 OIG comprehensive healthcare inspection and 2022 VHA Office of the Medical Inspector report recommendations were closed; however, as of June 23, 2025, the 2023 OIG hotline healthcare inspection follow up report had one open

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

[45] 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.

[46] The Ongoing Professional Practice Evaluation process is used to monitor a licensed independent health care practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

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

recommendation to the VISN Director.[48] Executive leaders said they review compliance for all oversight report action plans monthly.

The OIG also reviewed patient safety events and noted many were related to laboratory staff's delayed or unsuccessful communication of critical test results to the provider who ordered the test or a designee. The laboratory manager said department staff had also recognized these challenges and initiated a project in which they now receive a list of providers monthly, along with their contact information. The manager said the project improved staff's communication of critical test results.

Staff also said they review patient safety reports to determine whether there were multiple similar events warranting a root cause analysis.[49] VA staff can use the root cause analysis process to identify the cause of a patient safety event and implement actions to prevent future harm.[50] The OIG requested a list of root cause analyses completed in the past three years related to communication of test results, and one manager explained they did not conduct any.

However, the managers said that in November 2023, there were 85 overdue root cause analysis actions. They reported tracking 17 of the actions, and 6 had been open longer than one year. The OIG reviewed the overdue action plan log and noted staff did not document an update for all actions. For example, staff documented some actions as in progress or ongoing, but others had no comment. VHA requires staff to monitor root cause analysis actions and outcomes.[51] VHA guidance further states that staff should complete root cause analysis actions within one year.[52] The Chief of Staff attributed the delays in completing actions to previously having one patient safety manager to monitor the process. The chief explained they currently have three patient safety managers.

The patient safety managers added they discovered that many of the employees assigned to implement the actions no longer worked at the facility. Therefore, they worked with current employees to decrease the number of overdue actions, which decreased to 6 at the time of the

[48] VA OIG, *Comprehensive Healthcare Inspection of the John D. Dingell VA Medical Center in Detroit, Michigan*, Report No. 20-01273-162, June 23, 2021; VA OIG, *Review of VISN 10 and Facility Leaders' Response to Recommendations from a VHA Office of the Medical Inspector Report, John D. Dingell VA Medical Center in Detroit*, *Michigan*; Department of Veterans Affairs, *Report to the Under Secretary for Health, John D. Dingell Veterans Affairs Medical Center, Detroit, Michigan*.

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

[50] Department of Veterans Affairs, *VHA National Center for Patient Safety, Guide to Performing Root Cause Analysis,* Version 11, July 2023.

[51] Department of Veterans Affairs, *VHA National Center for Patient Safety, Guide to Performing Root Cause Analysis*.

[52] Department of Veterans Affairs, *VHA National Center for Patient Safety, Guide to Performing Root Cause Analysis*.

inspection in August 2024. The OIG recognizes the facility's efforts to address the overdue actions and did not make a recommendation.

## 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.[53] 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.[54] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

During an interview with the OIG, Quality Department leaders indicated they identify patient safety deficiencies through many avenues, such as patient safety reports. The Chief of Staff shared how staff identified safety events, conducted investigations, and implemented corrective actions that would prevent future similar events from happening.


The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[55] 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.[56] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[57] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

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

[54] VHA Directive 1050.01(1).

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

[56] 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).

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

During an interview, primary care leaders informed the OIG that most vacancies in the prior 12 months had been in licensed practical nurse positions, with four vacancies in August 2024. Primary care and executive leaders stated they hired health technicians to help cover these positions. Primary care leaders said lower VA pay, as compared to the community, contributed to difficulties retaining and recruiting licensed practical nurses. An executive leader said leaders increased pay for the position, which improved the retention rate.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[58] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[59]

The OIG reviewed primary care data from the first quarter of FY 2023 through the second quarter of FY 2024. During that time, panel sizes did not exceed VHA's expected baseline capacity of 1,200 patients per provider.[60] During an interview, primary care staff said they considered the current panel sizes manageable.

The OIG also found that appointment wait times ranged from four to six days for established patients, and four to nine days for new patients. Staff shared practices to ensure more efficient scheduling. For instance, each primary care team had a dedicated support staff member responsible for scheduling appointments. Additionally, providers described reviewing upcoming scheduled appointments to determine whether the patient's concern could be addressed in another way. For example, if a patient was scheduled for a medication refill, the provider might be able to address it with a phone call, which opened the appointment slot for another patient.

## Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[61] 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.

Staff said they initiated several process improvement projects in the primary care service. For example, they noticed many unscheduled visits were related to veterans requesting immunizations. Staff proposed an immunization clinic, run by registered nurses, where veterans could receive immunizations that did not require a provider's order. Leaders approved the clinic,

[58] "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).

[59] VHA Directive 1406(2).

[60] VHA Directive 1406(2).

[61] VHA Handbook 1101.10(2).

which has been open for about one year. Staff added the clinic has decreased the number of veterans waiting for a same day primary care appointment for immunizations.

## The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that enrollment declined from FYs 2021 through 2023. Primary care leaders said more veterans were located outside the Detroit metro area, so they opened community-based outpatient clinics to serve them. Leaders opened one clinic in Trenton, Michigan, and executive leaders planned to open another in Macomb County within two years.


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

## 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.[62]

### 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).[63] 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."[64]

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

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

[64] 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.

The national VA Homeless Programs Office exempted the facility's program from the HCHV5 performance measure for FYs 2021 through 2023.[65] During an interview, HCHV staff said the office granted the exemption because of the low homeless veteran population in the area. Staff added the number of homeless veterans in the area had decreased due to the effectiveness of programs like Housing and Urban Development–Veterans Affairs Supportive Housing and Supportive Services for Veteran Families, as well as strong community partnerships that provide resources to veterans.[66]

HCHV staff also told the OIG they use many methods to identify homeless veterans and enroll them in the program. Staff said they participate in outreach activities at soup kitchens, shelters, churches, and community organizations; and conduct annual census counts across five counties. Staff shared that outreach efforts go beyond just providing information about homeless resources, they also help veterans register for VA services, such as primary and dental care.

The HCHV program includes peer support specialists, who are veterans themselves, to help build trust and rapport with the veterans the program serves. Staff stated that the specialists can help ease the veterans' engagement and assessment processes. By referring to each other as "brother" or "sister," peer support specialists create a supportive and relatable environment that helps veterans feel more comfortable.

***Figure 9.*** *Best practice for veteran engagement.*
*Source: OIG interview.*

## 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] The program met the HCHV1 and HCHV2 targets in FY 2023.

Staff attributed their success partly to collaboration with community partners, who provide essential needs such as food, shelter, and legal services. For example, program staff shared they work with "rotating shelters," where several churches and other community organizations shelter

[65] "The mission of the Homeless Programs Office (HPO) is to assist Veterans and their families in obtaining permanent and sustainable housing with access to high-quality health care and supportive services." "VA Homeless Programs, About the Homeless Programs Office," Department of Veterans Affairs, accessed December 11, 2024, https://www.va.gov/about_homeless_programs.asp.

[66] The Supportive Services for Veteran Families "program provides supportive services to very low-income Veteran families in or transitioning to permanent housing" and provides funds "to private, non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive services designed to promote housing stability." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[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*.

individuals experiencing homelessness during a designated period, particularly during colder months. As an informal measure of success, staff said veterans often return to express gratitude and update them on their progress and employment status.

## 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."[68] 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.[69]

### 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).[70] The program did not meet the target in FY 2023.[71] Program staff said they are unable to address certain factors that may prolong the process of securing housing, such as past evictions or criminal records; however, they have some landlords who are flexible. Additionally, staff explained some veterans with vouchers wished to live in areas without available housing.

Staff explained that when veterans initially seek housing assistance from the program, staff place them in a temporary shelter and refer them for permanent housing. Staff also shared they collaborate with community partners through Supportive Services for Veteran Families, who conduct outreach in areas where homeless populations might be found, to refer homeless veterans to the program. In addition, staff described meeting weekly with community partners to track veterans until they obtain permanent housing. Furthermore, staff said that during their meetings, a team of facility psychiatrists, psychologists, substance use disorder specialists, occupational therapists, and medical staff discuss veterans' needs and goals.

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

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

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

[71] The facility's HMLS3 performance for FYs 2021 through 2023 was 82 percent, 75 percent, and 79 percent, respectively.

### 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).[72] The facility met target for FYs 2021 through 2023. Program staff attributed this success to dedicated vocational support staff, the compensated work therapy program, and personalized career planning to help veterans reenter the workforce.[73] Staff highlighted that they assist veterans with building resumes and locating employment. Staff added that some veterans who started with the compensated work therapy program have transitioned to full-time employment, including in positions at the facility.

## Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[74] 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.[75]

### Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[76] The facility's program exceeded the target for FY 2023.[77] During an interview, Veterans Justice Outreach staff explained the program receives referrals from the community, and staff assist veterans with specific needs. The staff explained that they educate veterans on the benefits of VA programs, such as those focused on personal health and well-being, to encourage enrollment.

[72] 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*.

[73] Compensated work therapy "is comprised of the transitional work and supported employment program, which assists homeless Veterans in returning to competitive employment." "VA Homeless Programs, VA Programs for Homeless Veterans," Department of Veterans Affairs, accessed September 17, 2024, https://www.va.gov/homeless/for_homeless_veterans.asp.

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

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

[76] 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*.

[77] The facility's FY 2023 consecutive quarterly VJP1 performance was 24 percent, 55 percent, 77 percent, and 108 percent in quarters one through four, respectively.

### Meeting Veteran Needs

Program staff told the OIG that through collaboration with community partners, the program can offer resources and referrals for legal services. Staff also partner with community law organizations to hold a weekly walk-in clinic at the facility to offer veterans information on legal housing rights. In addition, they explained that legal aid professionals help in community locations that provide landlord clinics and other workshops.

## Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to furnishings, navigation, cleanliness, equipment, and privacy. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Response). 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

Executive leaders ensure staff fix or replace damaged furnishings to allow effective cleaning and disinfection.

_X_ Concur

____ Nonconcur

Target date for completion: April 2026

### Director Comments

The facility concurs with this recommendation. The Associate Director and Chief, Facilities Management Service are responsible for implementation and sustainment of the corrective action to address the finding of lobby seating with damaged upholstery. In June 2024, an assessment of lobby furniture was conducted to identify furniture needs and replacement. The facility has been replacing furniture throughout the lobbies over the course of 2 years. The blue lobby is the last location to have the dated and worn furniture replaced. The facility placed an order for replacement furniture on December 31, 2024. The estimated delivery and installation date is October 15, 2025. A monthly inspection will begin on September 19, 2025, to determine compliance. Compliance is determined by the total number of lobby seats with intact upholstery out of the total number of lobby seats. Compliance will be reported at the Quality and Patient Safety (QPS) Board by the Chief of QPS in the accreditation report and will continue until 90% compliance is achieved for six consecutive months.

## Recommendation 2

Executive leaders ensure staff place paper maps at information desks to assist veterans in navigating the facility.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

### Director Comments

The facility concurs with this recommendation. The Assistant Director reviewed the process of wayfinding with the Chief of Veteran Experience on September 8, 2025. Paper maps through Medmaps software were revised and are available at the information desks for Veterans as needed. These maps were made available on September 8, 2025. In addition, Veterans are instructed on the use of the interactive electronic map that can be accessed on their personal

devices through a QR code at the information desks and at each elevator. The facility requests closure of this recommendation.

### OIG Comments

The OIG considers this recommendation closed.

## Recommendation 3

Executive leaders ensure staff store clean equipment in a sanitary environment.

_X_ Concur

____ Nonconcur

Target date for completion: April 2026

### Director Comments

The facility concurs with the recommendation. The shower chair and bedside commode have been removed from the Emergency Department shower room. This equipment has been relocated to the clean equipment room and staff will retrieve items when needed. The Chief of Quality and Patient Safety (QPS) is responsible for monitoring compliance by ensuring the facility conducts weekly audits of clean and dirty storage areas. Areas will be assessed for soiled items and overall cleanliness of storage area. Weekly audits began on September 11, 2025. Compliance is determined by the number of areas meeting standards over the total number of monitored areas. Compliance will be reported to the Quality and Patient Safety Board by the Chief of QPS in the accreditation report and will continue until 90% compliance is achieved for six consecutive months.

## Recommendation 4

Executive leaders ensure hallways and exits are free from obstruction.

_X_ Concur

____ Nonconcur

Target date for completion: April 2026

### Director Comments

The facility concurs with this recommendation. Frontline staff were provided education on The Joint Commission (TJC) standard LS.02.01.20: The hospital maintains the integrity of the means of egress in September 2025. The Chief of Quality and Patient Safety is responsible for monitoring compliance by ensuring the facility conducts weekly accreditation rounds to audit patient care departments for compliance. Areas will be assessed for compliance with TJC

hallway standards, which require corridors to have clear egress paths, maintained exit access, and to be free of obstructions such as clutter and unattended equipment. Weekly audits began on September 11, 2025. Compliance is determined by the total number of areas meeting standards over the total number of monitored areas. Compliance will be reported to the Quality and Patient Safety Board by the Chief of QPS in the accreditation report and will continue until 90% compliance is achieved for six consecutive months.

## Recommendation 5

Executive leaders ensure staff remove defective equipment from clinical areas to prevent use.

_X_ Concur

____ Nonconcur

Target date for completion: April 2026

### Director Comments

The facility concurs with this recommendation. The Chief of Quality and Patient Safety (QPS) is responsible for monitoring compliance by ensuring the facility conducts weekly audits of clinical areas for defective and damaged equipment. Areas will be assessed for defective equipment observed in clinical areas and storage rooms. Weekly audits began on September 11, 2025. Compliance is determined by the total number of inspections where clinical areas were free of defective, damaged, or potentially harmful equipment over the total number of areas inspected. Compliance will be reported to the Quality and Patient Safety Board by the Chief of QPS in the accreditation report and will continue until 90% compliance is achieved for six consecutive months.

## Recommendation 6

Executive leaders ensure staff have computer screen privacy filters to protect patients' personally identifiable information.

_X_ Concur

____ Nonconcur

Target date for completion: April 2026

### Director Comments

The facility concurs with this recommendation. The Associate Director and Privacy Officer are responsible for implementation and sustainment of these corrective actions to address the identified finding. The facility has conducted an assessment of workstations to determine the risk of confidential patient information being viewed publicly. Department supervisors have verified

that computer stations maintain privacy standards. All departments were reviewed in September 2025. Additional privacy screens were ordered on September 15, 2025, by the Chief of Logistics. The estimated delivery date is September 25, 2025. A monthly audit will begin on September 19, 2025, to determine compliance. Compliance will be measured by the number of publicly facing computers with privacy screens over the total number of publicly facing computers. Compliance will be reported to the Quality and Patient Safety Board by the Chief of QPS in the accreditation report and will continue until 90% compliance is achieved for six consecutive months.

# 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 seven 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from August 20 through 22, 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.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2023.

[2] The OIG sent a questionnaire to seven VSOs based on VA's statement that "VA works most closely with [these organizations]." VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/opa/docs/remediation-required/veo/traditionalVeteranOrganizations.pdf. The following VSOs responded to the questionnaire: Knights of Columbus, Non-Commissioned Officers Association, Disabled American Veterans, Wolverine Chapter 67, and American Legion.

[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.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[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.*

## 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. |
| | Facility Quit Rate | Voluntary resignations and losses to another federal agency. |

| Category | Metric | Metric Definition |
|---|---|---|
| | Facility Retire Rate | All retirements. |
| | Facility Termination Rate | Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments. |

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

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: September 10, 2025

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

Subj: Healthcare Facility Inspection of the VA Detroit Healthcare System in Michigan

To: Director, Office of Healthcare Inspections (54HF05)

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

1. I have reviewed and concur with the response for the draft report of our Healthcare Facility Inspection of the VA Detroit Healthcare System in Michigan.
2. I concur with the responses and actions plans submitted by the Detroit VA Medical Center Director.
3. Thank you for the opportunity to provide an update on this case.

*(Original signed by:)*

Beth Lumia, MSW

# Appendix D: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: September 10, 2025

From: Director, VA Detroit Healthcare System (553)

Subj: Healthcare Facility Inspection of the VA Detroit Healthcare System in Michigan

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

1. VA Detroit Healthcare System received the VA OIG Draft Report entitled "Healthcare Facility Inspection of the VA Detroit Healthcare System in Michigan" on August 26, 2025.
2. Director's Comments in response to the OIG's recommendations are attached to this memorandum.

*(Original signed by:)*

Ronald Beems, MHA, BSN
Associate Director for PCS
for
Christopher W. Cauley, FACHE
Medical Center Director

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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