



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee

**Healthcare Facility
Inspection**

25-00194-239

October 10, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the Eastern Oklahoma VA Health Care System (facility) from January 14 through 16, 2025.¹ The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Staff responses to an OIG questionnaire identified turnover in key leadership positions, and leaders noted the planned move of the facility from its current location in Muskogee to a new VA medical center in Tulsa in 2026 as system shocks.

The Director described a complete turnover of executive leaders within a three-year period. Further, an Associate Director for Patient Care Services was not permanently assigned until six months prior to the inspection. The Director discussed a goal to stabilize the executive team's positions with permanent leaders instead of temporary ones.

Leaders said the move to Tulsa would be challenging for many because the new medical center is 50 miles away from the current facility, and staff have strong ties to the Muskogee community. The Associate Director for Patient Care Services said executive leaders communicated all plans related to the move to staff.

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.

Executive leaders said they use multiple methods to communicate with staff. They meet with them daily, hold town halls, send email newsletters every week, and visit them in their work areas. They also said employees engage more readily with them and are comfortable providing feedback.

Executive leaders discussed the importance of modeling the behavior they want to see in others and setting an expectation that staff behave similarly. They also said staff had “challenging” conversations with them, which they interpreted as increased levels of psychological safety.

Executive leaders described several methods they use to identify patient concerns, such as receiving emails, letters, and telephone calls. They established patient advocate champions for each service and a Veterans Advisory Council to address veterans’ concerns.² Leaders shared an example in which veterans complained to a patient advocate about long wait times to get toenail care. To address this issue, nurses received foot care training and opened nail care clinics.

Environment of Care

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

The OIG found the facility welcoming, with adequate parking, bus, and shuttle services. The OIG was able to easily navigate within the facility using color-coded maps. The facility also had tools to help sensory-impaired veterans get to their destinations, including braille and audio cues at elevators, and volunteers and staff available at the front entrance to assist as needed.

The OIG found the facility’s toxic exposure screening program, established under the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act, had more than the recommended number of toxic exposure navigators, and a navigator reported that no screenings were overdue greater than 30 days.³

The facility was generally well-maintained; however, the OIG found dirty refrigerators and freezers in the critical care unit, medical surgical unit, and Emergency Department; and a dirty sink in the critical care unit’s medication room. The OIG issued a related recommendation.

² 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/>.

³ 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).

The OIG also found patients' personal medications stored in the medical surgical unit's medication room. Because leaders corrected the issue while the OIG was on-site, the OIG did not issue a recommendation.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG reviewed the facility's communication process for urgent, noncritical abnormal test results. The OIG found the facility lacked required service-level workflows (explaining staff member roles in the communication process) for urgent, noncritical test results. The OIG recommends facility leaders ensure staff develop these workflows.

VHA requires facility leaders to monitor the effectiveness of the patient notification process.⁴ Leaders said they monitor test result alerts in the electronic health record system to determine whether providers acted on them but admitted that responding to alerts was not the same as communicating the results. The OIG recommends executive leaders monitor the effectiveness of the patient notification process.

The OIG found that facility staff engage in process improvement efforts through various channels, such as daily meetings between executive and service-level leaders and quality management staff. Executive leaders also empowered staff to propose improvement initiatives. For example, a certified nursing assistant suggested leaders would reduce costs and wait times by transporting patients from the facility to the Oklahoma City VA Medical Center for medical testing rather than paying for non-VA care.

Primary Care

The OIG determined whether the primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the PACT Act affected the primary care delivery structure and new patient appointment wait times.⁵

Facility staff supplied documentation that identified provider, nurse, and administrative associate vacancies for primary care teams. Facility leaders said budget constraints required them to prioritize positions for hire based on need. Leaders also said they struggled to retain staff in primary care due to competing positions in other facility services, so they offered staff incentives to stay, such as special salary rates and student loan forgiveness.

⁴ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

⁵ PACT Act.

The OIG reviewed primary care team data and found that most providers' panel sizes (the number of patients assigned to a care team) were within VHA guidelines.⁶ Primary care staff told the OIG their workload was generally manageable. The OIG found leaders and staff identified issues affecting efficiency and engaged in process improvements. The Chief Nurse of Primary Care shared an example of an improvement initiative in which staff at one community-based outpatient clinic implemented 30-minute nursing appointments before primary care appointments. The nurses completed preventive assessments and other administrative tasks, and therefore, providers had more time to address patients' medical concerns.

The OIG noted veteran enrollment at the facility decreased overall in fiscal year (FY) 2022 but had started to increase again since FY 2023; facility leaders attributed the decrease to closure of the Vinita community-based outpatient clinic. Leaders told the OIG they conducted several PACT Act outreach events to increase enrollment, established a tribal partnership with Cherokee Nation and launched a clinic that provides care to Native and non-Native veterans in the Vinita area.

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 Health Care for Homeless Veterans program increased staffing in FY 2023 and expanded outreach to identify and enroll homeless veterans, meeting their performance target for completing program intake assessments for the first three quarters of FY 2024.

Housing and Urban Development–Veterans Affairs Supportive Housing program staff reported multiple challenges finding permanent housing for homeless veterans, including lack of affordable housing and difficulty locating housing for veterans with criminal backgrounds and poor rental histories. Staff said the local government had developed a 10-year plan to build affordable housing, and staff met with community partners to discuss using vouchers to house homeless veterans with criminal backgrounds and poor rental histories.

Program staff discussed their tribal partnerships and programs, which are unique to their service area. Leaders hired a Tribal Housing and Urban Development–Veterans Affairs Supportive Housing Supervisor to work with tribal nations. Staff highlighted their collaboration with the Muskogee Nation, the Choctaw Nation, and the Osage Nation to develop additional housing for tribal veterans, with some units dedicated to veterans using the program's vouchers.

⁶ VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025.

The Veterans Treatment Court Program Manager and liaison connect veterans with housing and employment services.⁷ Program staff also participated in a collaborative grant with tribal partners as one of four mentor court programs that help agencies establish veterans treatment courts in their service areas. They previously worked with tribes across the nation, including the Navajo Nation and those from the Pacific Northwest and had begun working with the Cherokee Nation to set up the first tribal veterans treatment court in the facility's service area.

What the OIG Recommended

The OIG made three recommendations.

1. Facility leaders ensure staff follow facility policies and maintain a clean environment.
2. Facility leaders ensure staff develop service-level workflows for the communication of urgent, noncritical test results.
3. Executive leaders monitor the effectiveness of the patient notification process.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with our findings and recommendations and provided acceptable action plans (see appendixes C and D). The OIG will follow up on the planned actions until they are completed.



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

⁷ A veterans treatment court “is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager.” VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Abbreviations

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

FACILITY IN CONTEXT

Description of Community

MEDIAN INCOME

\$46,506

EDUCATION

88% Completed High School
53% Some College

POPULATION

Female
903,885

Veteran Female
10,612

Male
883,416

Veteran Male
109,593

Homeless - State
3,754

Homeless Veteran - State
273

VIOLENT CRIME

Reported Offenses per 100,000

239

SUBSTANCE USE

26.5% Driving Deaths Involving Alcohol

14.5% Excessive Drinking

492 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+

5% Veterans Unemployed in Civilian Workforce

AVERAGE DRIVE TO CLOSEST VA

Primary Care **36.5 Minutes, 32 Miles**

Specialty Care **64.5 Minutes, 66 Miles**

Tertiary Care **122.5 Minutes, 134.5 Miles**

TRANSPORTATION

Drive Alone	630,498
Carpool	75,854
Work at Home	41,336
Walk to Work	13,466
Other Means	11,003
Public Transportation	2,550

ACCESS

VA Medical Center
Telehealth Patients **12,129**

Veterans Receiving Telehealth (VHA) **41%**

Veterans Receiving Telehealth (Facility) **32%**

<65 without Health Insurance **21%**

Access to Health Care

Health of the Veteran Population

228

VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

10,717

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.88 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)

28

Veteran Suicide Rate (state level)

46

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care

43K

Unique Patients VA Care

41K

Unique Patients Non-VA Care

24K

Health of the Facility

COMMUNITY CARE COSTS

Unique Patient

\$23,180

Outpatient Visit

\$266

Line Item

\$1,035

Bed Day of Care

\$281

STAFF RETENTION

Onboard Employees Stay <1 Yr

13.06%

Facility Total Loss Rate

9.89%

Facility Retire Rate

1.89%

Facility Quit Rate

7.19%

Facility Termination Rate

0.87%

★ VA MEDICAL CENTER
VETERAN POPULATION

0.04% 4.04% 8.03% 12.02% 16.01% 20.01%

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Background and Vision

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

The OIG established the Healthcare Facility Inspection cyclical review program to help accomplish its mission. 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.

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,



Figure 1. VHA's high reliability organization framework.

Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."

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

and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

High Reliability Organization Framework

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



Figure 2. Potential benefits of HRO implementation.

Source: Department of Veterans Affairs, “VHA High Reliability Organization (HRO), 6 Essential Questions,” April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.⁷ Over time, however, facility leaders who prioritize HRO principles increase

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.

employee engagement and improve patient outcomes.⁸ The OIG inspectors observed how facility leaders incorporated high reliability principles into their operations.

PACT Act

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

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

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

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 Jack C. Montgomery VA Medical Center of the Eastern Oklahoma VA Health Care System (facility) opened in 1923, and its service area covers Muskogee, Tulsa, Idabel, McAlester, and Vinita, Oklahoma. In fiscal year (FY) 2023, the facility had 60 operating hospital beds and a budget of \$730 million.

The OIG inspected the facility from January 14 through 16, 2025. Facility staff reported the executive leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, Assistant Director, and acting Associate Director. The Associate Director was temporarily assigned to another facility. The Director was assigned in February 2023. The newest member of the leadership team, the Associate Director for Patient Care Services, had been in the role for six months, whereas the most tenured, the Assistant Director, had served since November 2022.



CULTURE

A 2019 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.”¹³ Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.¹⁴ The OIG examined the facility’s culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees’ and veterans’ experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.¹⁵

¹³ Valerie M. Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies,” *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

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

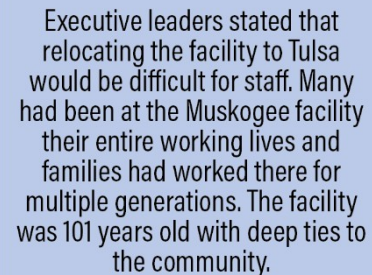
¹⁵ For more information on the OIG’s data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.¹⁶ By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.¹⁷ 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.

OIG questionnaire respondents identified turnover in key leadership positions as a system shock, and leaders named the planned move from the current facility to a new VA medical center in Tulsa as another. The Director stated the facility gained a completely new executive leadership team during the three years prior to the inspection. According to the Director, due to the multiple leadership changes, frontline staff would not invest in executive leaders' goals until they were confident the team members were committed to staying. The Director explained their goal was to stabilize the team by hiring permanent leaders rather than having staff fill the roles temporarily.

During an interview, executive leaders discussed another system shock related to the construction of a new VA medical center in Tulsa, planned for completion in 2026, and the subsequent transfer of services from the facility to the new medical center. According to leaders, the 50-mile distance from the facility to the new medical center was an issue for staff, and relocating would be difficult for many due to family ties to the Muskogee community. The Associate Director for Patient Care Services stated the executive leaders communicated plans for every step of the transfer process to staff.



Executive leaders stated that relocating the facility to Tulsa would be difficult for staff. Many had been at the Muskogee facility their entire working lives and families had worked there for multiple generations. The facility was 101 years old with deep ties to the community.

Figure 4. Facility system shocks.

Source: OIG interview.

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

¹⁷ Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.¹⁸ 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.¹⁹ 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."²⁰

EXECUTIVE LEADER INFORMATION SHARING

Leaders explained that to increase transparency, they will use an electronic visual management system to share standard communications and improvement projects with employees across all services.

Figure 5. *Leader communication with staff.*

Source: An interview with facility leaders.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.²¹ The facility's survey scores increased from FY 2021 to 2023 and were higher than VHA for communication and information sharing in FY 2023, and higher for transparency in FYs 2022 and 2023. During an interview, leaders said they conduct town halls, send weekly email newsletters, and visit employees in their work areas to share information. Leaders shared that they initially struggled to get input from employees; however, employees are now more comfortable providing feedback on communication efforts because of how readily leaders engage with them.

Leaders also said they implemented a tiered huddle system (daily meetings where information flows to and from frontline employees and leaders) to ensure communication between employees in different services. The Associate Director for Patient Care Services said all midlevel service leaders attend the huddles.

¹⁸ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

¹⁹ 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*.

²⁰ The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-edition, LD.03.04.01, January 14, 2024.

²¹ 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.²² Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.²³ The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

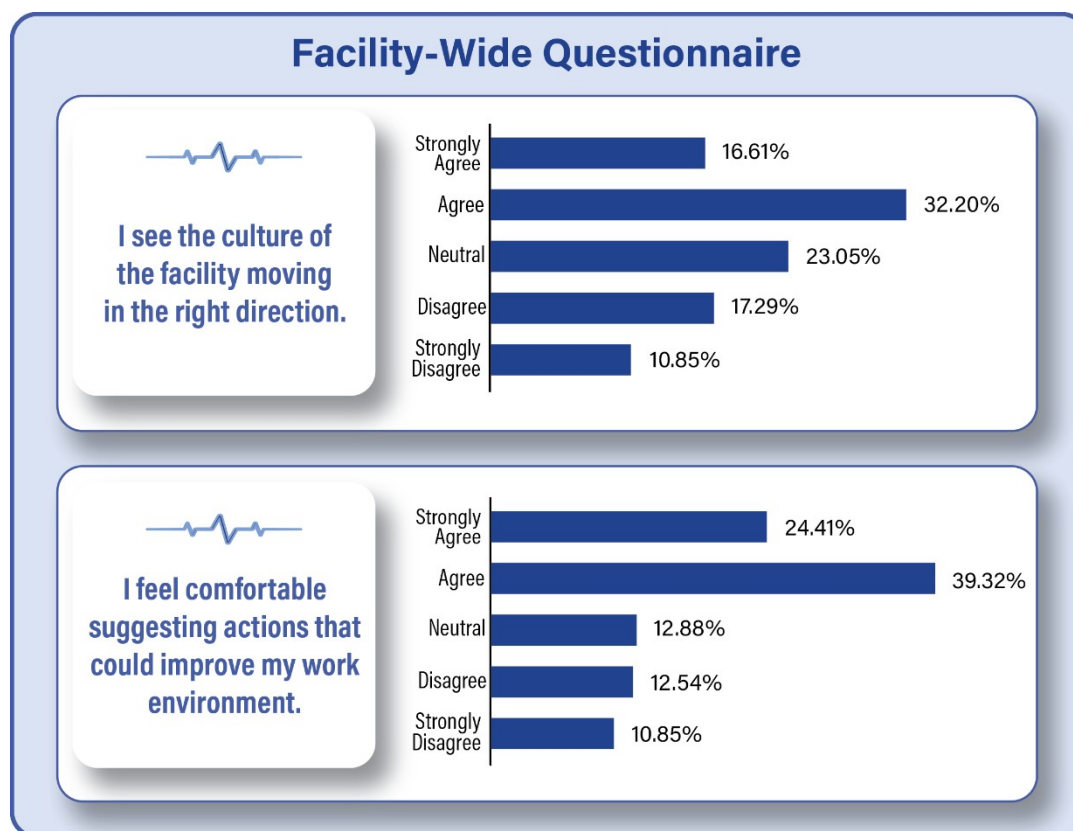


Figure 6. Employee and leaders' perceptions of facility culture.

Source: OIG questionnaire responses.

VA survey scores for best places to work, fear of reprisal, and psychological safety increased from FYs 2021 to 2023. Survey scores related to supervisor trust also increased from FY 2021 to 2022 but then decreased in FY 2023, although they were still higher than they were in FY 2021.

²² "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>.

²³ 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>.

These scores indicated leaders effectively addressed employees' concerns. For example, executive leaders stated that employees recently began to have "challenging" conversations with them, which they interpreted as a culture shift that indicated employees had increased levels of psychological safety. When asked about the decrease in the FY 2023 supervisor trust score, executive leaders stated employees may have been overwhelmed by leaders deciding to use available resources more efficiently rather than hiring additional employees.

Executive leaders stressed that it is important for them to model the behavior they want to see in others and then set the expectation for employees to conduct themselves in a similar manner. The Director identified vulnerability as a key leadership characteristic, saying leaders must be able to ask employees what is wrong, admit errors, and apologize for mistakes. Leaders held and participated in engagement activities with employees, such as karaoke, line dancing, and pickleball. After receiving feedback in previous years that community-based outpatient clinic employees felt left out of these activities, the leaders intentionally included them.



The Director described monthly one-hour lunches with six employees from different services throughout the facility. During the lunch, the Director addresses concerns raised by the attendees and later follows up with them as needed. The Director stressed that follow-up is important to maintain employees' trust.

Figure 7. Highlighted information related to the staff survey.
Source: OIG interview.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.²⁴ The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

During an interview, the Director said they learned about veterans' concerns through patient advocate reports, emails, letters, and telephone calls from veterans. The Veteran Experience Officer started the Veterans Advisory Council, which includes veterans, to provide leaders with input on various issues. The Veteran Experience Officer also provides quarterly trend data to the Director on veterans' concerns.

Executive leaders explained their process to address veterans' concerns. They said there is a patient advocate champion for each service who addresses issues. If the champions are unable to resolve the problems, they escalate them to executive leaders.

Facility leaders reported complaints to patient advocates were related to provider changes, lack of communication with medical staff, and care coordination issues. Veterans also complained

²⁴ "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, <https://www.va.gov/HEALTH/patientadvocate/>.

about long wait times to get toenail care.²⁵ To reduce wait times, nurses received specialized training and opened nail care clinics.



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.²⁶ 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 8. Facility photo.

Source: "VA Eastern Oklahoma Health Care," Department of Veterans Affairs, accessed February 19, 2025, <https://www.va.gov/eastern-oklahoma-health-care/locations>.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.²⁷ 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.²⁸

²⁵ Receiving regular toenail care is important for foot health, especially in patients with diabetes, to prevent ingrown toenails, infections, and other foot problems. "Diabetes Foot Care Tips," American Diabetes Association, accessed July 14, 2025, <https://diabetes.org/health-wellness/diabetes-and-your-feet/foot-care-tips>.

²⁶ VHA Directive 1608(1).

²⁷ 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>.

²⁸ Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, January 2024; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

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

The OIG noted the parking areas near the main entrance were covered and had adequate lighting and call boxes. The parking areas met VA's design standards for having enough accessible parking for individuals with disabilities. The OIG observed

additional parking down the hill from the facility with shuttle service to the main entrance. The OIG also noted a visible police presence both outside and throughout the facility.

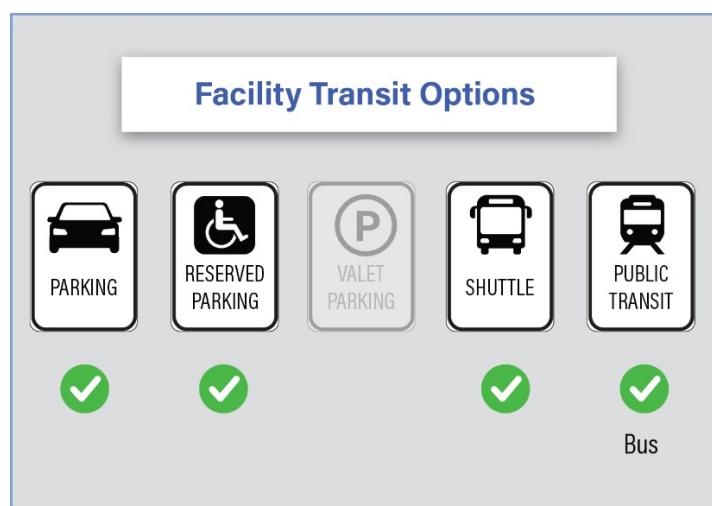


Figure 9. Transit options for arriving at the facility.

Source: OIG analysis of documents and interviews.

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.²⁹

The main entrance was located within steps of the public bus and VA shuttle stop, and the secondary entrance was adjacent to the shuttle area. Both entrances had ramps available for veterans with disabilities to use, if needed. The main entrance was well-lit and welcoming with seating areas, an information desk, and a coffee vendor. The OIG observed veterans socializing and interacting with facility staff.

²⁹ VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.³⁰

The OIG team used commercial navigation applications to reach the facility and found the directions to be accurate. The OIG noted wheelchairs at the main entrance and color-coded maps of the facility positioned at the entrance, on walls, and near elevators.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.³¹ The OIG observed braille text and audio instructions for visually impaired veterans at elevators, and staff and volunteers to help veterans navigate the facility.



Figure 10. Accessibility tools available to veterans with sensory impairments.

Source: OIG observations and analysis of documents.

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.³²

Information desk staff said they direct veterans to specialty and primary care clinics where staff provide them with toxic exposure screening information, resources, and screening appointment availability. The facility had three navigators. One navigator explained that primary care staff

³⁰ VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

³¹ 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.

³² 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.

complete most screenings during primary care appointments and complete the remaining follow-up (second) screenings in 30 days or less; the OIG confirmed this when reviewing toxic exposure screening data.³³ The navigator also said staff can screen veterans during walk-in appointments in primary care, and primary care providers are trained to answer toxic exposure questions. The navigator added that there was sufficient space and resources to support the program.

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.³⁴

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 repeat findings. The Accreditation Specialist said staff report the progress of action plans to the Quality Patient Safety Committee for a minimum of 22 months to ensure they sustain improvements.

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.

Given the advanced age of the facility, the OIG found it was generally clean and well-maintained. However, the sink and surrounding area in the critical care unit's medication room were dirty and had hardwater deposits. In addition, the OIG noted dirty refrigerators and freezers in food storage areas in the critical care and medical surgical units and Emergency Department. VHA requires staff to ensure a clean and safe environment.³⁵ The infection preventionist stated there is a policy outlining cleaning responsibilities; however, facility leaders said staff do not follow it.³⁶ The OIG recommends facility leaders ensure staff follow facility policies and maintain a clean environment.

³³ VHA Support Service Center.

³⁴ Department of Veterans Affairs, *VHA HRO Framework*.

³⁵ VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.

³⁶ Eastern Oklahoma VA Health Care System, "Safety and Sanitation of Nourishment Areas" (standard operating procedure), May 2020.

In the medical surgical unit, OIG found that staff stored patients' personal medications in a wire bin in the medication room. The Joint Commission requires staff to remove contaminated medications and store "them separately from medications available for administration."³⁷ Facility leaders stated they were unaware of the issue. Staff removed the personal medications from the medication room, and facility leaders trained them on appropriate storage processes while the OIG was on-site. Therefore, the OIG did not issue a recommendation.



PATIENT SAFETY

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.³⁸ Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.³⁹

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG found the facility lacked service-level workflows that outlined roles and responsibilities of all team members in the communication process, as required.⁴⁰ The OIG recommends facility leaders ensure staff develop service-level workflows for the communication of urgent, noncritical test results.

During an interview, facility leaders explained that when a provider receives a test result that requires action, the electronic health record generates a clinical alert. Providers then take appropriate actions to resolve that alert. Facility leaders said they track the number of unresolved

³⁷ The Joint Commission, *Standards Manual*, E-dition, MM.03.01.01, January 1, 2025. Microorganisms may be transmitted by hands or a patient's environment; therefore, personal medications are generally considered contaminated. Vincenzo Russotto, et al., "Bacterial Contamination of Inanimate Surfaces and Equipment in the Intensive Care Unit," *Journal of Intensive Care* 3, no. 1 (2015): 54, <https://doi.org/10.1186/s40560-015-0120-5>.

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

³⁹ Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, <https://doi.org/10.1515/dx-2014-0035>.

⁴⁰ VHA Directive 1088(1).

test result alerts and report them to the Medical Staff Executive Committee and the Health Informatics Committee for oversight. However, leaders acknowledged that a provider resolving an alert in the electronic health record does not equate to notifying the patient of the result nor does it meet VHA's requirement to communicate the results to the patient within seven days.⁴¹

While leaders monitored test result alerts in the electronic health record system, the Chief of Staff reported they did not use any other methods to ensure providers communicated test results to patients within the required time frame. VHA requires facility leaders to monitor the effectiveness of the patient notification process.⁴² The chief added that leaders would review and improve their processes to ensure providers communicate the results as required. The OIG recommends executive leaders monitor the effectiveness of the patient notification process.

Action Plan Implementation and Sustainability



Figure 11. Status of prior OIG recommendations.
Source: VA OIG.

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.⁴³ The OIG evaluated previous facility action plans in response to oversight report recommendations

to determine if action plans were implemented, effective, and sustained.

The OIG found no open recommendations from the reports it published during the previous three years. Executive leaders and quality management staff said that when an oversight agency issues a recommendation, they develop action plans to address the issue. They then report, discuss, and track the actions at oversight committees to ensure staff implement them in a timely manner and sustain improvements.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.⁴⁴ Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing

⁴¹ VHA Directive 1088(1).

⁴² VHA Directive 1088(1).

⁴³ VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

⁴⁴ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

actions to address the deficiencies, and communicating lessons learned.⁴⁵ 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 interviews, facility leaders and quality management staff said that as part of their continuous improvement process, executive and service-level leaders meet daily with quality management staff to discuss potential projects. The Chief of Quality explained that staff from each service must identify at least two projects, develop and implement action plans, monitor results until they achieve desired outcomes, ensure they sustain improvement, and report their progress to the Quality and Safety Committee. The Systems Redesign Coordinator also told the OIG that staff identify process improvement projects as part of the facility's patient safety programs.⁴⁶

Facility leaders and quality management staff also discussed executive leaders' commitment to empowering frontline staff to suggest process improvement projects. Systems Redesign staff shared an example of a project that a certified nursing assistant proposed to executive leaders. The assistant suggested leaders would reduce costs and wait times by transporting patients from the facility to the Oklahoma City VA Medical Center for medical testing rather than paying for non-VA care, and developed a process improvement project for the idea. The Chief of Quality said executive leaders educate staff about process improvement projects, which has increased their trust and willingness to participate in these projects.



PRIMARY CARE

The OIG determined whether the primary care teams were staffed per VHA guidelines and received support from leaders.⁴⁷ 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.

⁴⁵ VHA Directive 1050.01(1).

⁴⁶ "Systems Redesign and Improvement is the VHA practice of utilizing improvement tools to conduct Continuous Process Improvement (CPI). The practice evaluates and analyzes operational processes and procedures for the purpose of driving continuous improvement to increase/decrease output, increase efficiency, or increase the effectiveness of the process or procedure." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁴⁷ VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.⁴⁸ The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.⁴⁹ The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Facility staff provided the OIG with documentation that showed primary care vacancies for two providers, four nurses, and one medical support assistant. Facility leaders discussed budget constraints and said they worked with executive leaders to prioritize positions to fill. While teams were not fully staffed, facility leaders said they hired a pool of float providers (providers who are not assigned to a team) and used other clinical staff to cover vacant positions.

Leaders had assigned several float providers to panels full-time, which limited their availability to cover other providers' unexpected absences. Facility leaders and primary care staff told the OIG this led to appointment cancellations and required staff to reschedule patients. Facility and executive leaders were aware of this issue and working on solutions to balance clinical staffing and maintain timely access to care. The OIG reviewed facility data and found the average new patient appointment wait time was approximately six days in the fourth quarter of FY 2024.

Facility leaders said they do not have challenges recruiting qualified candidates for primary care, but they do in retaining them due to workload and competition with other services at the facility. The Chief of the Business Office and Chief Nurse of Primary Care added that medical support assistants and licensed practical nurses may have higher earning potential or promotion opportunities outside of primary care. Facility leaders stated they offered incentives for staff to stay in primary care, such as loan forgiveness and special salary rates for medical support assistants.

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.⁵⁰ The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.⁵¹

⁴⁸ 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).

⁴⁹ VA OIG, [*OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*](#), Report No. 23-00659-186, August 22, 2023.

⁵⁰ "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).

⁵¹ VHA Directive 1406(2).

VHA expects full-time primary care teams with adequate staffing and space to maintain baseline panel sizes of 1,200 patients, noting most teams fall within a range of 1,000 to 1,400.⁵² The OIG reviewed facility data and found most panel sizes were within VHA guidelines. Program staff provided reasons some teams fell outside expected ranges and shared that facility leaders met regularly to discuss panels, staffing, and enrollment trends, then adjusted teams as needed. For example, several teams have newer providers, and leaders expect to increase their panel sizes over time. Additionally, some providers are assigned additional duties, such as serving as primary care leaders, and facility leaders adjusted their panels proportionately.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.⁵³ 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.

The OIG found facility leaders and staff engaged in continuous process improvement efforts and worked to improve efficiency and workflow. Primary care staff said their workload was generally manageable; however, a high volume of electronic alerts added to the administrative burden of providers. Facility leaders reported they educated providers on how to adjust settings in the electronic health record system to minimize alerts, while ensuring the system communicated critical information in a timely manner. Primary care staff said these efforts were helpful and they believed leaders would continue to address their concerns.

The Chief Nurse of Primary Care discussed a 90-day pilot program to implement 30-minute nursing appointments prior to primary care appointments at one community-based outpatient clinic. During these nursing appointments, staff completed preventive assessments and other administrative items, which allowed the provider more time to address patients' medical concerns during the scheduled appointment time. Facility leaders said this program also improved Healthcare Effectiveness Data and Information Set hypertension (high blood pressure) metrics at the clinic.⁵⁴ Leaders had expanded the pilot from the one community-based outpatient clinic to others and planned to implement it throughout the system by the end of FY 2025.

⁵² VHA Directive 1406(2).

⁵³ VHA Handbook 1101.10(2).

⁵⁴ "HEDIS, the Healthcare Effectiveness Data and Information Set, is a standardized population health management tool that employers can use to understand the health of their employees and measure the quality of care their population receives." "What is HEDIS?, Leveraging HEDIS to Measure Health Quality Care," The National Committee for Quality Assurance (NCQA), accessed May 13, 2025, <https://www.ncqa.org/NCQA-HPA-MeasuringHCQ-HEDIS-WEB.pdf>.

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 veteran enrollment decreased in FY 2022 but had started to increase in FYs 2023 and 2024.

During an interview, facility leaders attributed the decline in enrollment to closing the Vinita community-based outpatient clinic, which they closed because the cost to renew the lease exceeded the lease's market value. Leaders explained that when the clinic closed, some veterans enrolled at another VA facility in the region. To encourage veterans to return to the facility, leaders stated they partnered with tribal leaders to establish a clinic in the Cherokee Nation Vinita Health Care Center, which provides services to both Native and non-Native veterans in the area. In addition, facility staff conducted PACT Act outreach events, which will continue through FY 2025, to enroll new veterans and encourage those previously disenrolled to return.

Primary care staff explained they did not complete the initial training for the PACT Act before they started performing toxic exposure screenings, which resulted in longer initial screening appointments and incomplete and overdue screenings. Primary care staff said providers spent a lot of time addressing veterans' questions about future follow-up requirements, benefits, and compensation, which limited their time to discuss other medical issues during appointments. Staff added that they later received training; gained knowledge about the process; and became more comfortable over time with performing screenings and addressing follow-up questions.



VETERAN-CENTERED SAFETY NET

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.⁵⁵

⁵⁵ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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).⁵⁶ 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."⁵⁷

The OIG found the facility's program did not meet the target for FY 2023. However, program staff reported they hired additional outreach staff in FY 2023 and met the target from the first through the third quarter of FY 2024. Program staff said adding additional staff allowed them to

- participate in outreach events with community partners at more locations and with greater frequency;
- resume street outreach, where they make direct contact with homeless veterans in the community; and
- support walk-in clinic hours at the facility and in Tulsa, where homeless veterans obtain information regarding available resources.

Program staff stated community partners allowed them to access the Homeless Management Information System (database that non-profit and community agencies use to track homeless individuals) to identify veterans for the program. Program staff also explained they, along with facility leaders, participated in the biennial point-in-time count. In addition, they helped community partners establish temporary overflow shelters because shelters were at maximum capacity in Tulsa the week prior to the OIG site visit in January 2025.

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).⁵⁸

The program met the HCHV1 target from FY 2023 through the third quarter of FY 2024. Program staff reported they had good relationships and worked closely with contracted

⁵⁶ VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022.

⁵⁷ 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.

⁵⁸ 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*.

residential services staff, which was a reason for meeting the target.⁵⁹ Staff said they met weekly with the contracted residential services case managers to discuss veterans and ensure staff helped them to achieve their goals. Program staff also worked closely with Housing and Urban Development–Veterans Affairs Supportive Housing program staff to ensure they completed the paperwork needed for veterans to receive housing vouchers.

The program met the HCHV2 target for FY 2023, but not for FY 2024 quarters one through three. Program staff reported that some veterans have been discharged from contract residential facilities without obtaining permanent housing more than once due to continued mental health or substance abuse issues. Staff said they offered interventions for these issues, including contract residential facility housing, but some veterans still exited the program. Additionally, staff explained that locating permanent housing can take a long time, which leads to fewer exits to permanent housing overall.

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.”⁶⁰ 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.⁶¹

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).⁶² The OIG found that despite staff’s outreach efforts, the program did not meet the target for FY 2023 through the third quarter of FY 2024.

⁵⁹ There are two models for Contract Residential Services programs. Under the Contract Emergency Residential Services model veterans can usually stay in housing from 30 to 90 days. Under the other model, Low Demand Safe Havens, veterans can typically stay in housing between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

⁶⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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

⁶² 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*.

Program staff attributed this to the lack of affordable housing and difficulty locating housing for veterans with criminal backgrounds or poor rental histories. Staff explained that landlords were demolishing properties and upgrading rental units, which decreased housing availability and allowed landlords to charge higher rental fees. This resulted in fewer available rental properties for veterans. Staff stated the local government was aware of the housing issue and had developed a 10-year plan to build affordable housing. Staff met with community partners to discuss using vouchers for special housing, such as assisted living facilities, and housing for homeless veterans with criminal backgrounds and poor rental histories, to permanent housing to help support the program. Staff anticipate these additional housing options will improve their performance.

Program staff reported the facility led the nation in tribal partnerships and programs, which are unique to their service area. Additionally, they told the OIG that tribal nations decide how they implement housing programs, and tribal housing entities provide higher rental rates for veterans that used those funds. These higher rates offer more housing options for veterans belonging to those tribes.

Program staff explained tribal housing programs also differ from traditional housing programs in terms of eligibility. To qualify for traditional housing programs, a veteran must be homeless or at imminent risk of homelessness (homeless without assistance within 14 days). Tribal housing program rules, which are consistent with Native American cultural norms, qualifies veterans who live in overcrowded housing even if they are not strictly homeless or at imminent risk of homelessness.

Leaders hired a Tribal Housing and Urban Development–Veterans Affairs Supportive Housing Supervisor, who established beneficial relationships with tribal nations. Program staff told the OIG they were collaborating with community partners and the Muskogee Nation to develop additional housing for tribal veterans, the Choctaw Nation to expand the geographic area where tribal veterans can use their vouchers, and the Osage Nation to build housing with some units dedicated to homeless veterans using the program’s vouchers.

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).⁶³ The program met the target for FY 2023 through the third quarter of FY 2024. Program staff explained they collaborated closely with employment program partners and have employment specialists with over 10 years of experience with the program to help veterans find employment.

⁶³ 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*.

Staff shared that the facility had two Compensated Work Therapy programs that employed veterans, one at the Jack C. Montgomery VA Medical Center in Muskogee and the other at the community-based outpatient clinic in Tulsa.⁶⁴ Program staff also received approval for 30 additional positions at the new VA medical center in Tulsa when it opens.

Veterans Justice Program

“Incarceration is one of the most powerful predictors of homelessness.”⁶⁵ 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.⁶⁶

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).⁶⁷ The facility did not meet the performance measure for FY 2023 but did meet it through the third quarter of FY 2024. The Veterans Justice Outreach Specialist reported staff performed outreach in FY 2023 but did not correctly document it in the national database that tracks the measure, due in part to a staff member not having access to the database. In February 2024, facility leaders officially reassigned the staff member to the Veterans Justice Program, which allowed access to the database and increased the metric.

Staff stated they receive program referrals from veterans; facility and community providers; veterans’ family or friends; jail and court staff; law enforcement; veterans organizations; and community partners, including tribal programs. The outreach specialist used telephone and virtual communications to have more frequent and efficient contact with incarcerated veterans and meet with courts and community partners.

Meeting Veteran Needs

The Veterans Treatment Court Program Manager and the Veterans Treatment Court Liaison worked with veterans treatments courts and connected veterans to other services, such as housing

⁶⁴ “Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers.” “Veterans Health Administration, Compensated Work Therapy,” Department of Veterans Affairs, accessed September 12, 2024, <https://www.va.gov/health/cwt/>.

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

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

⁶⁷ 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*.

and employment.⁶⁸ The Veterans Justice Outreach Coordinator described attending meetings with veterans' healthcare teams to coordinate care and contacted community providers who partner with courts to care for veterans who are ineligible for VA care.

Staff reported the program previously participated in a collaborative grant with tribal partners as one of four mentor court programs that assist and train agencies to set up veterans treatment courts in their service areas. Program staff worked with tribes across the nation, including the Navajo Nation and tribes from the Pacific Northwest. Program staff had started working with the Cherokee Nation to set up the first tribal veterans treatment court in the service area, using the court in Tulsa as a model.

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 cleanliness and test result communication. 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.

⁶⁸ A veterans treatment court "is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

OIG Recommendations and VA Responses

Recommendation 1

Facility leaders ensure staff follow facility policies and maintain a clean environment.

☒ Concur

☐ Nonconcur

Target date for completion: February 28, 2026

Director Comments

Eastern Oklahoma Health Care System Executive Leadership Team reviewed the facility's current process for maintaining a clean environment in clinical food storage and medication rooms/sinks. Nutrition and Food Services began auditing cleanliness of the nine (9) food storage areas in March 2025 to ensure compliance with SOP 120-F-06. Data collected (Denominator) is Nourishment Rooms, refrigerators and freezers in patient food storage areas. The numerator is number of Nourishment Rooms, refrigerators and Freezers that are clean. Nutrition and Food Services' benchmark is 90% or better. The Chief of Nutrition and Food Services reports compliance rates to the Quality and Patient Safety Committee monthly until six consecutive months of 90% compliance, or better, have been achieved.

Environmental Management Services will begin auditing sinks in the seven (7) patient units' medication rooms to ensure they are clean, free of hardwater stains and deposits. The denominator is the number of units with medication rooms (7), and the numerator is the number of sinks in patient units' medication rooms clean, free of hardwater stains and deposits. The Chief of Environmental Management Services will report compliance rates to the Quality and Patient Safety Committee monthly until six consecutive months of 90% compliance, or better, have been achieved.

Recommendation 2

Facility leaders ensure staff develop service-level workflows for the communication of urgent, noncritical test results.

☒ Concur

☐ Nonconcur

Target date for completion: November 1, 2025

Director Comments

The Executive Leadership Team of the Eastern Oklahoma Health Care System conducted a review of current facility procedures for timely patient notification of urgent, noncritical test results. The Chief of Staff will ensure that both inpatient and outpatient clinical service lines develop standardized workflows tailored to each specific setting for communicating these test results. All clinical service line Chiefs and Managers (100%) will receive training on the appropriate workflow for their respective settings. Clinical service line Chiefs will provide a signed attestation confirming they have educated their service line Managers on these workflows and that the Managers have educated frontline staff and implemented the new process. The measure of compliance will be determined by the ratio of educated clinical service line Chiefs providing attestations (numerator) to the total number of clinical service line Chiefs across all clinical service lines (denominator).

Recommendation 3

Executive leaders monitor the effectiveness of the patient notification process.

☒ Concur

☐ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Eastern Oklahoma Health Care System Executive Leadership Team reviewed existing facility processes for monitoring the effectiveness of notification of test results to patients. The Chief of Staff will implement a monthly random audit for all clinical service lines (n=11) to monitor the documentation and timeliness of provider communication to patients for urgent, noncritical test results. Beginning October 2025, compliance rate for the total sample of 55 clinical charts per month will be reported monthly by the Chief of Staff, or designee, to the Quality and Patient Safety Committee. The Chief of Quality and Patient Safety will then report the results to the Medical Executive Committee monthly.

Compliance will be defined as the presence of documented Veteran notification of test results compliant with Veterans Health Administration Directive 1088. Monitoring and compliance will continue until a minimum of 90% compliance is sustained for six consecutive months. Audits will include an assessment of compliance with all times frames for notification of results as outlined in Veterans Health Administration Directive 1088.

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. 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*.²

Potential limitations include self-selection bias and response bias of respondents.³ 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 January 14 through 16, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁴ The OIG reviews available evidence within a specified

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

² Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

³ 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>.

⁴ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 19, 2025

From: Director, Rocky Mountain Network (10N19)

Subj: Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee

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

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee.
2. Based upon a thorough review of the report by VISN 19 leadership, I concur with the findings, recommendations and submitted action plans of Eastern Oklahoma VA Health Care System. As we remain committed to ensuring our Veterans receive exceptional care, VISN 19 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have any questions or require further information, please contact the VISN 19 Quality Management Officer.

(Original signed by:)

Chelsea Childress

Interim Deputy Network Director, VA Rocky Mountain Network (10N19)
for

Sunaina Kumar-Giebel, MHA

Director, VA Rocky Mountain Network (10N19)

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2025

From: Director, Eastern Oklahoma VA Health Care System (623)

Subj: Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the Eastern Oklahoma VA Health Care System in Muskogee.
2. I have reviewed the report and concur with all recommendations. Action plans have been developed or implemented and are identified in the Director Comments.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions, please contact the Chief of Quality or the VISN 19 Quality Management Specialist.

(Original signed by:)

Kimberly Denning, DNP, RN
Executive Director
Eastern Oklahoma VA Healthcare System

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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