US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Sioux Falls Health Care System in South Dakota

Healthcare Facility Inspection	24-03420-18	December 10, 2025

OUR MISSION

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

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Sioux Falls Health Care System (facility) from December 3 through 5, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders and staff did not identify any recent system shocks. The leaders explained they rely on the knowledge and expertise of their staff to manage issues when they arise, acknowledging the importance of subject matter experts.

Executive leaders prioritized good communication and shared information through several methods, including town halls, regular email updates, and visits to work areas. The OIG found that, overall, executive leaders were aware of employees' and veterans' needs and took steps to minimize any effects of employee turnover and staffing issues on patient care and employees' stress and burnout.

[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.

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 and easy to navigate, with accessible information on toxic exposure screenings.[2] However, the OIG's review of facility documents, as well as interviews and on-site inspections, revealed ongoing deficiencies related to construction safety. Several construction areas did not have the required VHA Pre-Construction and Infection Control Risk Assessment permits posted, and the Construction Safety Committee's chair was not a member of the executive leadership team, as required. The OIG issued recommendations to address these findings. In response, the Director provided evidence that an executive leader was appointed as chair of the Construction Safety Committee, and the OIG considers this recommendation closed. The Director also reported that staff will ensure construction locations have the required posted permits (see OIG Recommendations and VA Responses).

The OIG inspected five clinical areas and found them to be generally clean, well-lit, and clutter-free. However, the OIG also found several exam rooms that lacked privacy curtains, which shield exam tables when the door is open, compromising patient privacy. Further, the hallway in the Community Living Center did not have handrails installed on both sides to ensure patient safety, as required.[3] The OIG issued related recommendations. The Director explained that to ensure veterans' privacy, housekeeping staff placed privacy curtains in exam rooms, and engineering staff will install handrails in the Community Living Center the week of November 24, 2025 (see OIG Recommendations and VA Responses).

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found that the facility had recently updated their policy and service-level procedures to align with the VHA directive for communicating test results to providers and

[2] The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act expanded VA health care and benefits to veterans exposed to toxic substances. PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[3] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed March 18, 2025, https://www.va.gov/VA_CLC; 42 C.F.R. § 483.90 (2025); VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.

patients.[4] In addition, there were no findings related to test result communication from external oversight or accreditation agencies in the previous three years.

Although clinical leaders reported no issues with diagnostic providers communicating abnormal results to ordering providers, they described challenges in obtaining timely patient test results from community care providers.[5] In response, executive leaders worked with two community healthcare systems to establish direct access to their electronic health record systems for facility providers. Facility providers are now able to immediately review veterans' test results from those community partners.

Although executive and clinical leaders are aware of delays in communicating abnormal test results to patients timely and have made some efforts to improve the process, patients are still experiencing delays in receiving their results. For example, the OIG reviewed patient safety events from October 2023 through October 2024, which showed delays with patients receiving test results. The OIG made a recommendation. As a result, the Director reported that facility leaders are developing an audit process to improve the communication of test results (see OIG Recommendations and VA Responses).

Quality management staff highlighted proactive continuous process improvement efforts, which include reviewing patient safety events with executive leaders daily, monitoring safety measure data, and discussing lessons learned in monthly forums. The OIG found that patient safety managers provided detailed summaries of events to the Quality and Patient Safety Committee quarterly.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the PACT Act implementation affected primary care delivery structure and new patient appointment wait times.[6]

The facility provided primary care through the main facility primary care clinic and five community clinics. The Administrative Officer, Primary Care reported these locations are staffed by 27 primary care teams. Furthermore, the OIG found that staff vacancies did not significantly disrupt primary care team workflows and patient access to care. Leaders leveraged available resources, such as the Veterans Integrated Service Network 23 Clinical Resource Hub, to cover a

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

[5] Community care is a program through which "VA provides care to Veterans through community providers when VA cannot provide the care needed," and is based on "specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed March 20, 2025, https://www.va.gov/CommunityCare.

[6] PACT Act.

provider vacancy at the Aberdeen clinic.[7] They also redistributed patients from primary care teams with provider vacancies to teams with fewer patients.

Primary care leaders and staff implemented process improvement projects aimed at reducing wait times for new patient appointments and reported that the average wait times decreased from 19 days in November 2023, to 14 days in February 2024. Additionally, primary care leaders described their efforts to reduce the volume of clinical view alerts, which are electronic health information notifications that require a provider's action, so they did not overwhelm providers. Finally, the OIG found PACT Act implementation had not increased veteran enrollment rates at the facility and had minimal effect on primary care workload and timeliness of care.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found that staff across the programs maintained strong teamwork as well as collaborative relationships with community partners who help to meet veterans' needs.

Additionally, the OIG found that Health Care for Homeless Veterans program staff conducted outreach activities and regularly met with program enrollees and community partners. As a result, they met the performance target for engagement with homeless veterans in fiscal year (FY) 2024 and exceeded the percentage of veterans discharged from the program into permanent housing from FYs 2022 through 2024.

The Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet the performance target for the percentage of housing vouchers assigned to the facility used by veterans in FY 2022. However, the program exceeded the target in FYs 2023 and 2024 because staff developed a collaborative relationship with public housing authority leaders. The program also did not meet targets for veteran employment from FYs 2022 through 2024; however, program staff explained an ongoing challenge with the measures including disabled or retired veterans who were not seeking work but identified as unemployed.

Because the Veterans Justice Program Coordinator misunderstood enrollment criteria, the facility did not meet the target for veterans entering the program in FYs 2023 and 2024. Veterans

[7] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed May 21, 2025, https://department.va.gov/integrated-service-networks/. "Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Patient Care Services, Clinical Resource Hubs (CRH)" Department of Veterans Affairs, accessed May 21, 2025, https://www.patientcare.va.gov/primarycare/CRH.asp.

Integrated Service Network leaders have since provided guidance to the coordinator about the criteria, and enrollment has begun to increase.

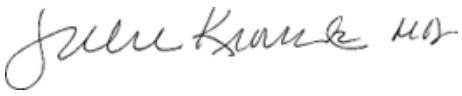
What the OIG Recommended

The OIG made five recommendations.

1. Executive leaders ensure staff post safety risk assessment permits for all construction projects.
2. The Director assigns a member of the executive leadership team as chair of the Construction Safety Committee to oversee safety activities.
3. Executive leaders ensure staff install privacy curtains in all exam rooms.
4. Executive leaders ensure staff install handrails on both sides of the hallway in the Community Living Center.
5. Executive leaders ensure staff follow the facility's policy for communication of abnormal test results to patients.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans (see OIG Recommendations and VA Responses and appendixes C and D for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 2 closed. For the remaining open recommendations, leaders are implementing corrective actions, and the OIG will follow up on the planned actions until they are completed.



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

Abbreviations

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

FACILITY IN CONTEXT

VA Sioux Falls Health Care System
Sioux Falls, South Dakota
Level 2-Medium Complexity
Minnehaha County
Hospital Referral Region: Sioux Falls

Description of Community

POPULATION

Female **522,386**	Male **530,333**
Veteran Female **5,863**	Veteran Male **58,804**

Homeless - State **1,389**
Homeless Veteran - State **40**

MEDIAN INCOME

$58,662

EDUCATION

92% Completed High School
69% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **117**

SUBSTANCE USE

31.6% Driving Deaths Involving Alcohol
22.5% Excessive Drinking
30 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	422,187
Carpool	44,460
Work at Home	36,854
Walk to Work	19,282
Other Means	6,181
Public Transportation	2,219

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**57 Minutes, 53 Miles**
Specialty Care	**110 Minutes, 111 Miles**
Tertiary Care	**217 Minutes, 232 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **6,501**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	26%
<65 without Health Insurance	12%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

4,920

106 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.30 Days

30-DAY READMISSION RATE

8%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
28	48

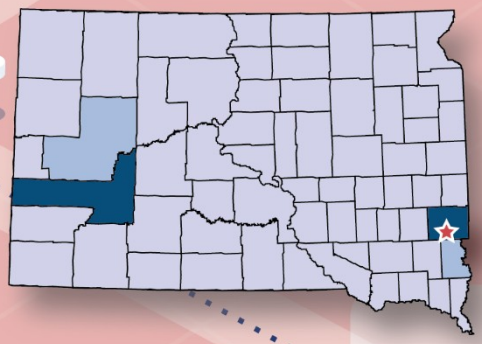
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	28K
Unique Patients VA Care	26K
Unique Patients Non-VA Care	17K

COMMUNITY CARE COSTS

Unique Patient $27,479	Outpatient Visit $285
Line Item $2,674	Bed Day of Care $267



STAFF RETENTION

Onboard Employees Stay <1 Yr	13.51%
Facility Total Loss Rate	9.63%
Facility Retire Rate	1.96%
Facility Quit Rate	7.02%
Facility Termination Rate	0.57%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.08% 4.16% 8.24% 12.31% 16.39% 20.45%

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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

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

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

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

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

Content Domains

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

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

The Royal C. Johnson Veterans' Memorial Hospital opened July 19, 1949, and is part of the VA Sioux Falls Health Care System (facility). The facility provides services to more than 30,000 veterans in Iowa, Minnesota, Nebraska, and South Dakota. The facility operates 28 hospital and 44 Community Living Center beds, and had a fiscal year (FY) 2023 medical care budget that exceeded $380 million.[13] It also has a Registered Nurse Residency Program, with the first group admitted in September 2023. The nurses participate in a year-long education and training program where they develop leadership and clinical skills.

The OIG inspected the facility from December 3 through 5, 2024. The executive team included the Executive Director (Director), Chief of Staff, Associate Director, and the Associate Director Patient Care Services/Nurse Executive. The Director was appointed to the role in March 2023. The most tenured executive leader was the Chief of Staff, who had been in the position since January 2018. The Associate Director and Associate Director Patient Care Services/Nurse Executive were permanently assigned in April and August 2020, respectively.

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

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 10, 2024, https://www.va.gov/VA_CLC.

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

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

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

System Shocks

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

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. When asked, executive leaders and most respondents to the OIG's facility-wide questionnaire indicated they had not faced recent system shocks.

Executive leaders explained that when potentially disruptive events occur, they involve facility subject matter experts to effectively address the issue. As an example, the Chief of Staff said a recent Baxter fluid supply shortage had the potential to disrupt operations at the facility.[19] The chief added that although the shortage had not yet affected patient care, leaders tasked key staff with monitoring the facility's fluid supply to minimize potential adverse effects, such as canceled surgical procedures.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] 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

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

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

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

[19] In September 2024 Hurricane Helene damaged a Baxter International facility, a leading US supplier of medical fluid solutions (including intravenous fluids), leading to limited hospital supplies nationwide. Department of Veterans Affairs, *Veterans Health Administration Guidance: Baxter Fluid Supply Management*, December 20, 2024.

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

culture.[21] 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."[22]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23] The OIG noted an overall improvement in survey scores for leadership communication from FYs 2021 through 2024. Executive leaders stated they worked on improving communication because in the survey, employees consistently identified this as a top area they wanted leaders to focus on (see figure 4).

EXECUTIVE LEADER INFORMATION SHARING
Executive leaders identified multiple methods for sharing information, including daily tiered huddles (a series of meetings for employees at different levels of responsibility), twice-a-week emails, monthly all-employee town halls, and leader rounding (visits to work areas).

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

In the facility-wide questionnaire, most respondents indicated executive leaders' communication was clear and useful, but infrequent. During an interview, the Director said that discussing reasons for budget, staffing, or other changes during town halls allow them to be proactive and transparent with employees. They record the meetings and periodically adjust the time and location to accommodate employees' various work schedules.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[24] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[25] 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.

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[21] 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*.

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

[23] 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.

[24] "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.

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

The facility's survey scores related to fear of reprisal, work group psychological safety, and best places to work improved overall from FYs 2021 through 2024. Additionally, the OIG's questionnaire results indicated that although employees generally feel comfortable suggesting ways to improve their work environment, they are concerned about stress and burnout.

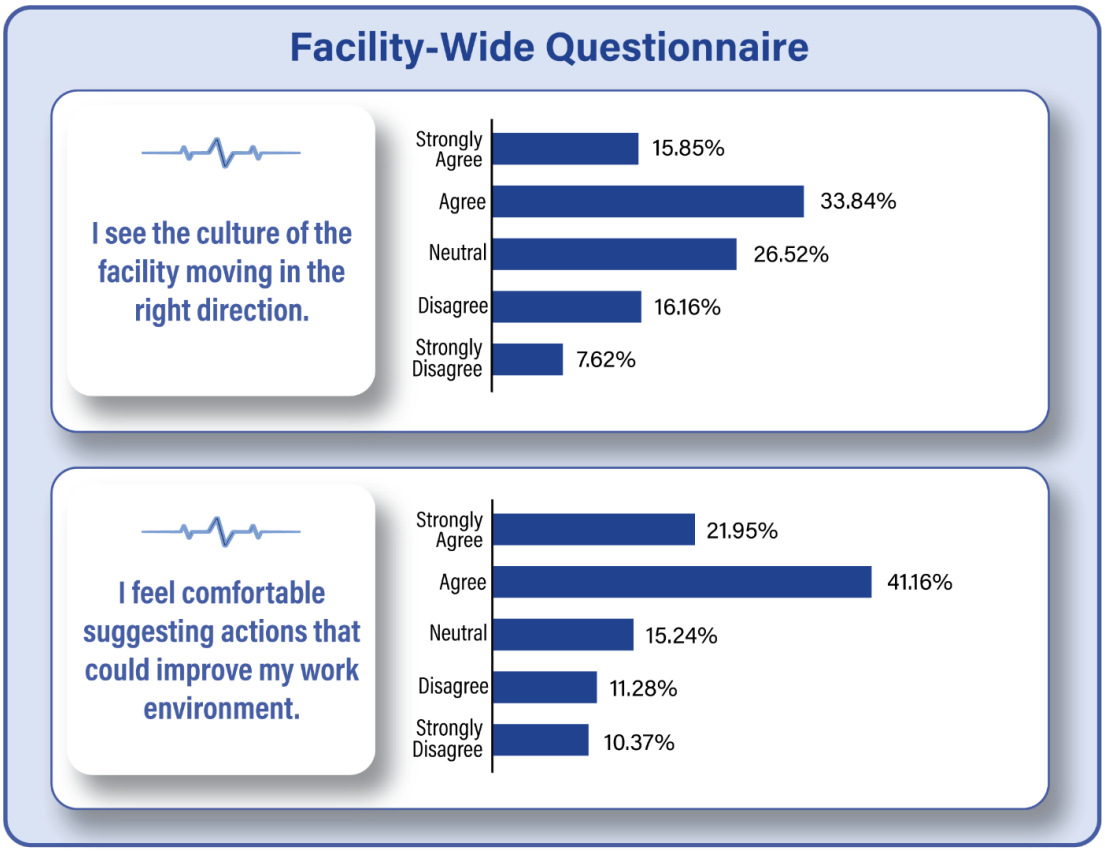

Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

Executive leaders said they believed stress and burnout are often related to staffing shortages in work areas. The leaders further stated that staffing shortages due to the COVID-19 pandemic specifically affected primary care, the Medical Surgical Unit, and the Community Living Center. They added that staffing continues to be a concern because of the facility's rural location and lower pay compared to community healthcare systems. To support employees experiencing burnout, the Director shared that the Employee Wellness Coordinator and other facility program managers meet with those groups to talk about their concerns. Executive leaders added they provide all employees with resources such as Employee Whole Health opportunities, including mindfulness exercises, yoga, and general education.[26]

[26] Employee Whole Health provides staff with resources to prioritize their health and well-being so they can better fulfill VA's mission to serve veterans, their families, caregivers, and survivors. "Whole Health, Employee Whole Health," Department of Veterans Affairs, accessed March 20, 2025, https://www.va.gov/WholeHealth.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[27] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[28] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Patient advocate and VSO representative questionnaire responses indicated they could provide feedback to executive leaders, and the leaders were responsive to veterans' concerns. Executive leaders said they rely on multiple mechanisms for gathering feedback about veterans' experiences. These include the Director being an active member of the South Dakota Veterans Advisory Council, which has representatives from VSOs across the state; meeting monthly with local VSOs, congressional delegates, and other community partners; and receiving daily updates from quality management staff and patient advocates.

The OIG noted that executive leaders, VSO representatives, and patient advocates identified travel pay reimbursement and community care billing and authorizations as common concerns for veterans.[29] Since veterans must confirm their arrival at the facility to file for travel benefits, executive leaders stated they implemented a phone application that veterans can use to check in. They explained that VA Beneficiary Travel national program office staff were adding community care appointments into the application, which will allow veterans to submit travel reimbursement requests for those appointments. For veterans who prefer not to use the phone application, staff assist them with submitting paper claims. In response to community care concerns, executive leaders created a customer service position to assist veterans with issues like incorrect community care billing, and local hospitals that send unpaid bills to collection agencies.

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

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

[29] "VA travel pay reimbursement pays eligible Veterans and caregivers back for mileage and other travel expenses to and from approved health care appointments." "File for Travel Pay Reimbursement," Department of Veterans Affairs, accessed September 16, 2025, https://www.va.gov/travel-pay. Community care "provides care to Veterans through community providers when VA cannot provide the care needed," and is based on "specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed March 20, 2025, https://www.va.gov/COMMUNITYCARE/.

ENVIRONMENT OF CARE

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

Figure 6. *Facility photo. Source: "Royal C. Johnson Veterans' Memorial Hospital," Department of Veterans Affairs, accessed April 28, 2025, https://www.va.gov/sioux-falls-health-care/locations.*

Entry Touchpoints

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

[30] VHA Directive 1608(1).

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

[32] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

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

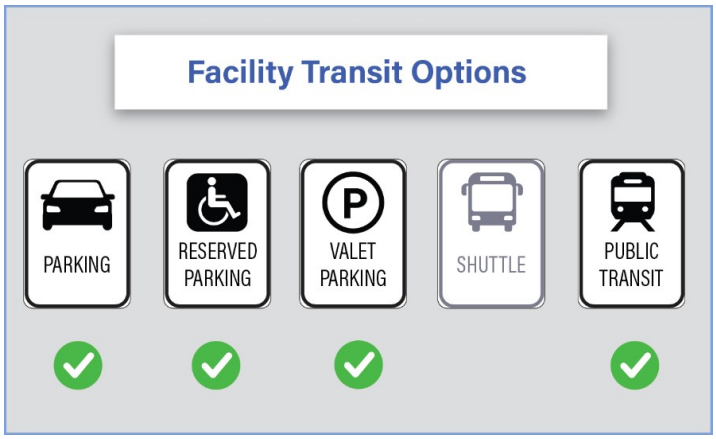

Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The OIG team located the facility using the directions from its website and on arrival noted a clearly marked parking lot. The OIG also confirmed that the facility offers valet parking services Monday through Friday, excluding federal holidays. Although the nearest bus stop is located a few blocks away, veterans may request transportation to the facility through the Sioux Area Metro on-demand system.[33]

Main Entrance

Figure 8. *Facility front entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[34]

The OIG easily located the main entrance using the navigational cues throughout the parking lot. The main entrance was covered and equipped with power-assisted doors. The OIG also noted wheelchairs readily available for use, along with volunteers near the information desk to assist veterans with transport. The OIG observed a clean, well-lit, and spacious main entrance area with sufficient seating, which contributed to an overall welcoming environment.

[33] "Veterans can ride the bus for free by showing a valid photo ID when boarding." "Programs," Sioux Area Metro, accessed September 3, 2025, https://siouxareametro.info/programs.

[34] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[35]

The OIG observed staff at the information desk who assisted veterans with directions and clear directional signs on the walls, making it easy to locate specific clinical and nonclinical areas. The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] Although the main entrance lacked sound-absorbing panels, the OIG did not hear excessive noise or interruptions that would impair communication between veterans and staff.

The staff at the information desk said they did not receive basic sign language training, but would escort veterans to their desired location, as needed. Additionally, signs and elevators included braille to help veterans with visual impairments.

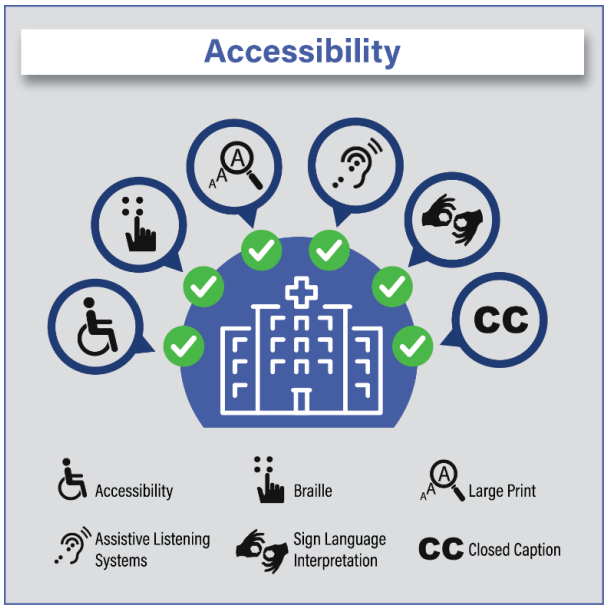

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG physical inspections.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[37]

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[35] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

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

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

The OIG confirmed the facility had two designated toxic exposure screening navigators, who are both nurse practitioners. One navigator explained that staff screen most veterans in primary care clinics. The screening process may include a secondary screen (conducted when a veteran reports a toxic exposure during the initial screening) in which the provider documents the veterans' exposure and initiates consults for follow-up care.

The OIG reviewed facility toxic exposure screening data and noted no unresolved secondary screens open longer than 30 days.[38] During the general inspection, the OIG observed informational signs about toxic exposure screening at the main entrance information desk and staff said they know how to locate the navigators.

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.[39]

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

The OIG reviewed meeting minutes from the Construction Safety Committee showing staff had completed the VHA Pre-Construction and Infection Control Risk Assessments for current construction projects. During an interview, the Chief of Engineering asserted that staff had posted risk assessment permits at active construction project sites. To verify this, the OIG inspected several of the sites and found some did not have a permit posted. VHA requires staff to post the permits at the entrance of active construction sites.[40] The staff members acknowledged the omissions but could not provide a reason for the noncompliance. Although not the same finding, the facility's January 2024 Annual Workplace Evaluation survey also noted noncompliance with construction safety standards and issued seven recommendations, which were closed at the time of the site visit in December 2024.[41]

Failure to post the required safety risk assessment permits at construction sites can increase the risk of injury and infection to patients, staff, or visitors. The OIG recommended executive

[38] VHA's expectation is that staff complete toxic exposure screenings within 30 days. Department of Veterans Affairs, *Toxic Exposure Screening Process*, updated January 2025.

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

[40] VHA Directive 7715(1), *Safety and Health During Construction*, June 22, 2023, amended September 5, 2023; Department of Veterans Affairs, *VHA Pre-Construction Risk Assessment (PCRA) Template*, VHA PCRA-1.1 (May 21, 2024), internal VA document.

[41] The Annual Workplace Evaluation assesses the facility's compliance with occupational safety and health requirements. VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, December 12, 2022.

leaders ensure staff post safety risk assessment permits for all construction projects. In response, the Director reported that staff will ensure construction locations have posted permits (see OIG Recommendations and VA Responses).

Additionally, the Construction Safety Committee meeting minutes from September to December 2024 identified the Chief of Engineering, who is not an executive leader, as the committee's chair. VHA requires directors to appoint a member of the executive leadership team as the chair, who ensures staff complete and post assessment permits.[42] The OIG recommended the Director assigns a member of the executive leadership team as chair of the Construction Safety Committee to oversee safety activities. The Director provided evidence that an executive leader was appointed as chair of the Construction Safety Committee, and the OIG considers this recommendation closed (see OIG Recommendations and VA Responses).

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy. The OIG inspected five clinical areas and found them to be generally clean, well-lit, and clutter-free.[43]

The OIG found several exam rooms without privacy curtains in the Primary Care Clinic. VHA requires facility staff to shield examination tables from view when the door is opened.[44] When the OIG asked about this observation, the Hospital Housekeeping Officer said clinical staff had removed the curtains when converting rooms from exam space to office space but did not reinstall them when they returned the room to clinical use. The OIG recommended executive leaders ensure staff install privacy curtains in all exam rooms. In response, the Director stated staff installed privacy curtains and will inspect the rooms monthly to ensure sustained compliance (see OIG Recommendations and VA Responses).

Additionally, during the general inspection of the Community Living Center, the OIG observed that handrails were installed on only one side of the hallway. The Code of Federal Regulations (C.F.R.) requires handrails on each side of corridors to provide a safe environment for residents.[45] The Associate Director said the criteria did not apply because the Community Living

[42] VHA Directive 7715(1).

[43] The OIG inspected the Primary Care Clinic, Emergency Department, Community Living Center, and Intensive Care and Medical Surgical Units.

[44] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[45] 42 C.F.R. § 483.90 (2025); VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.

Center is a home like environment and not a nursing home. However, when the OIG asked for the guidance used to determine this, the Associate Director was unable to provide it.

The absence of handrails on both sides of the hallway may affect the safety of veterans who may be at risk of falling. The OIG recommended executive leaders ensure staff install handrails on both sides of the hallway in the Community Living Center. The Director reported that staff began a project to install the additional handrails (see OIG Recommendations and VA Responses).

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.[46] 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.[47]

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. VHA requires facility staff to implement a local policy and service-level workflows, which describe team member roles in the communication process, for communicating the results to providers and patients.[48] The local policy should include details on how facility staff will monitor the effectiveness of the patient notification process. The OIG confirmed the facility's policy and service-level workflows aligned with VHA's directive.[49]

Executive and clinical leaders reported they currently monitor providers' compliance with communicating urgent, noncritical test results to patients in three ways: through the External

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

[47] 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.

[48] VHA Directive 1088(1).

[49] VA Sioux Falls Health Care System MCP [medical center policy] 11-100, *Communicating Test Results to Providers and Patients*, November 13, 2024.

Peer Review Program, electronic health record audits during providers' Ongoing Professional Practice Evaluations, and reviews of patient safety events.[50]

Patient safety staff described completing multiple performance improvement projects in the past three years to improve timely notification of abnormal test results. For example, they said the staff member assigned to monitor providers' notification of mammogram results was given other duties, which left no other staff to perform the task. As a result, the Patient Safety Manager said they noticed an increased number of events related to patients not receiving their mammogram results timely and implemented a consult tracking process.

During an interview, clinical leaders reported no issues with diagnostic providers communicating abnormal results to providers who order tests. However, leaders mentioned they had experienced challenges in obtaining timely test results when patients receive care in the community. To address this issue, they described a process improvement initiative they enacted two years prior that allowed facility providers to access two different community hospitals' medical record systems. This enabled the providers to directly view patients' test results rather than waiting for the community provider to contact them.

The OIG reviewed patient safety events from October 2023 through October 2024 that showed a trend with delays in facility and community providers communicating abnormal test results. The Chief of Staff reported that staff review safety events to determine the cause and severity of the event, and whether a root cause analysis is needed.[51] The chief also said leaders are looking to develop an internal process to monitor actionable results to make sure providers' communication is timely. Despite leaders' efforts, the OIG found patients continue to experience delays in receiving urgent, noncritical test results within seven days, as required.[52] The OIG recommended executive leaders ensure staff follow the facility's policy for communication of abnormal test results to patients. In response, the Director explained that leaders are developing an audit system to ensure timely test result communication (see OIG Recommendations and VA Responses).

[50] The External Peer Review Program supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. Veterans Health Administration Office of Informatics and Analytics, *Privacy Impact Assessment for the VA IT System called: External Peer Review Program (EPRP)*, March 15, 2022. The Ongoing Professional Practice Evaluation process is used to monitor a licensed independent health care practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

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

[52] VHA Directive 1088(1).

Action Plan Implementation and Sustainability

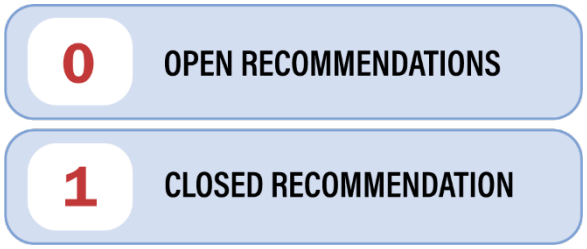

Figure 10. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[53] 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 findings related to communicating test results from oversight and accreditation reports from the past three years. In addition, the single recommendation from the OIG comprehensive healthcare inspection conducted in January 2023 was closed.[54]

The Accreditation Manager reported monitoring oversight agency findings, ensuring staff monitor actions for sustained improvement, and presenting quarterly progress reports to the Quality and Patient Safety Committee. The OIG reviewed the quarterly reports for this committee from October 2023 to July 2024, and confirmed the manager updated members on improvement actions from oversight and accreditation report findings.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[55] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[56] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality management staff described a noticeable increase in staff's focus on process improvements and reported patient safety events after the facility began tiered safety huddles in June 2023. Quality management staff said they believed the huddles, along with facility leaders

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

[54] VA OIG, *Comprehensive Healthcare Inspection of the Royal C. Johnson Veterans' Memorial Hospital in Sioux Falls, South Dakota*, Report No. 23-00006-03, October 24, 2023.

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

[56] VHA Directive 1050.01(1).

encouraging staff to be involved in process improvement activities, has supported a culture of safety and empowered staff to report concerns.

Patient safety staff said they review Joint Patient Safety Reporting system events and monitor low-performing or declining patient safety measures to identify opportunities for improvement.[57] They also share this information with executive leaders daily and communicate lessons learned from adverse events to staff during monthly patient safety forums.[58]

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[59] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[60] 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.[61] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The facility offers primary care services through the main facility primary care clinic and five community clinics. The Administrative Officer, Primary Care reported that 27 primary care teams had three vacant provider positions; two at the main facility clinic and one in the Aberdeen clinic. In addition, there were six nursing vacancies; two at the main facility and four at the community clinics. Primary care leaders said the vacancies were due to retirements, transfers within the facility, and departures to positions at non-VA hospitals.

[57] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

[58] Adverse events are defined as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[59] VHA Directive 1406(2); VHA Handbook 1101.10(2).

[60] 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).

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

The Primary Care Service Chief and the Facility Principal Coordinator said the vacancies had minimal effect on clinic workflows and access to care. The OIG reviewed new patient appointment data from October 2023 through September 2024 and determined wait times ranged from 14 to 23 days, based on the patient's desired appointment date. Additional discussion on patient access is in the Leadership Support section below. The Primary Care Service Chief added that primary care leaders partner with the Veterans Integrated Service Network (VISN) 23 Clinical Resource Hub for staffing support.[62] For example, a Clinical Resource Hub provider is covering a vacancy at the Aberdeen clinic until it is filled.

In an interview, a social worker said there are two social workers covering 16 primary care teams at the main facility. VHA suggests a staffing ratio of one social worker for every two primary care teams.[63] When social workers are assigned more than the recommended number of teams, the resulting demands may impede their ability to provide adequate services for the patients . The social work leader described meeting with social workers daily to discuss their workload, patient safety concerns, and ways to improve workflow efficiency. The OIG did not make a recommendation because VHA suggests but does not require a specific staffing ratio; however, executive leaders should reassess social workers' assignments.

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.[64] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[65]

The OIG determined that, on average, the primary care team panels were approximately 91 percent of VHA's expected size from July 2023 through June 2024.[66] The Facility Principal Coordinator reported meeting weekly with primary care leaders to discuss and adjust panel sizes, if needed, to ensure patients have access to care.

[62] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed May 21, 2025, https://department.va.gov/integrated-service-networks/."Clinical Resource Hubs (CRH) are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed May 21, 2025, https://www.patientcare.va.gov/primarycare/crh.asp.

[63] VHA Handbook 1101.10(2).

[64] "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).

[65] VHA Directive 1406(2).

[66] Based on a formula that includes the primary care team size, the maximum number of patients a primary care team is expected to care for is 1,200. VHA Directive 1406(2).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[67] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

In an interview, a primary care team member informed the OIG that overwhelming numbers of clinical view alerts are a major concern for providers.[68] To address this, the Chief of Staff stated that clinical leaders reviewed and removed non-mandatory alerts to decrease the number providers receive.

Additionally, the Group Practice Manager reported working with primary care staff on a process improvement project to decrease appointment wait times for new patients. The manager shared some of the strategies they implemented, including using float providers (providers who are not assigned to a team) to cover for staff on leave. Staff also review pending appointment reports each week to identify patients with the longest wait times and offer them earlier appointments when possible. As a result of these efforts, the manager stated that wait times for new patients declined from 19 days in November 2023 to 14 days in February 2024.

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 reviewed the facility's veteran enrollment data from FY 2021 through the second quarter of FY 2024 and found the act's implementation had not increased enrollment at the facility.

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.

[67] VHA Handbook 1101.10(2).

[68] A view alert is a brief interactive electronic notification in a computerized patient record system designed to inform the user about activities. Department of Veterans Affairs, Office of Information & Technology (OI&T), *Computerized Patient Record System (CPRS) User Guide: GUI Version*, October 2024.

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.[69]

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).[70] 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."[71]

The HCHV Program Coordinator said the VHA Homeless Programs Office exempted the facility's program from the performance measure in FYs 2022 and 2023 because the number of unsheltered veterans in the area was too small. Staff said they perform outreach at homeless shelters and parks and have strong relationships with community partners, who quickly connect unsheltered veterans to the program.

> The HCHV staff shared the story of an unsheltered veteran with severe mental illness who was initially reluctant to engage with VA. HCHV outreach staff spent approximately a year and a half building rapport with the veteran before they agreed to explore program housing options. HCHV staff explained that Housing and Urban Development–Veterans Affairs Supportive Housing program staff helped the veteran find and stay in housing for the past two years.

Figure 11. *Veteran engagement. Source: OIG interview.*

Program staff explained the facility's emergency department and front desk staff promptly refer unsheltered veterans to the HCHV program for assistance. HCHV staff then conduct intake assessments, determine veterans' needs, and develop a plan to connect them to needed resources. However, staff added that engaging unsheltered veterans can be challenging, especially those with mental illness. Their approach prioritizes building trust with veterans through consistent contact.

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

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

[71] 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.

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).[72]

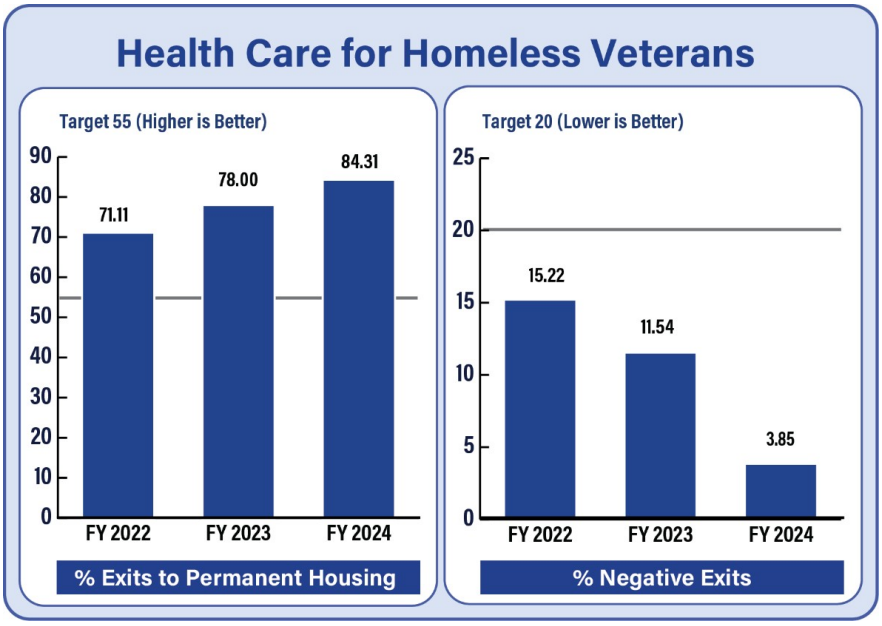

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The HCHV program exceeded the HCHV1 and HCHV2 targets from FYs 2022 through 2024. Program staff said they were successful with the HCHV1 measure because they met regularly with veterans throughout the housing process and worked closely with community partners to ensure a smooth transition to permanent housing. The staff stated they exceeded the HCHV2 target because they thoroughly assessed veterans' needs and maintained case management, which allowed them to provide essential support, such as referrals to substance abuse treatment, during the veterans' time in contracted emergency residential services.[73]

They also informed veterans about program rules such as curfews and chore requirements and collaborated closely with employees at the residential services. This enabled regular

[72] 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*.

[73] "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

communication about veterans' compliance with rules and strategies to assist those who were struggling, which reduced premature discharges.

Figure 13. *Facility's current community partnerships.*
Source: OIG analysis of documents and interviews.

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."[74] 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.[75]

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).[76]

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

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

[76] 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*.

The program exceeded the target for FYs 2023 and 2024 but did not meet it for FY 2022.[77] The program coordinator attributed improvements in FYs 2023 and 2024 to the program being fully staffed, as well as effective teamwork and strong communication and collaborative relationships between program staff and new leaders at the public housing authority. The program coordinator also told the OIG that staff regularly communicate with landlords in the community through text messages, phone calls, or emails to address their concerns. For example, if a landlord notifies staff that a veteran is late in paying rent, they connect the veteran with community resources for assistance.

The program coordinator reported the primary challenge to enrolling veterans is an insufficient number of vouchers, adding that staff had already issued all the vouchers allocated to the program. Staff then refer veterans who do not have a voucher for temporary housing until a voucher becomes available. To address this issue, the program coordinator planned to request additional vouchers in February 2025.

The Housing and Urban Development–Veterans Affairs Supportive Housing Program Coordinator explained that program staff assisted a veteran with two young children leaving a situation involving intimate partner violence. In collaboration with community partners, program staff provided various resources, including housing and day care assistance. With this support, the veteran returned to school, earned a bachelor's degree, and is now on track to graduate with a master's degree in social work. The veteran is completing an internship at the VA and has maintained stable housing for the past two years.

Figure 14. *Meeting veteran needs. Source: OIG interview.*

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[78] The program did not meet the target for FYs 2022 through 2024.[79] The program coordinator said a major challenge is that some veterans are either retired or disabled and not seeking work but identified themselves as unemployed. Despite these challenges, the OIG learned during the interview that program staff continue to encourage veterans to work and if they need help finding

[77] The HMLS3 target was 92 percent for FY 2022 and 90 percent for 2023 and 2024. The facility program attained 88, 94, and 95 percent for FYs 2022, 2023, and 2024, respectively.

[78] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

[79] The VASH3 target was 47 percent for FY 2022 and 50 percent for FYs 2023 and 2024. The facility program attained 31, 21, and 38 percent for FYs 2022, 2023, and 2024, respectively.

work, staff refer them to the compensated work therapy program or community partners who have employment programs.[80]

Additionally, the HCHV Program Coordinator reported HCHV and Housing and Urban Development–VA Supportive Housing staff work together with assisted living facilities and nursing homes to meet the needs of aging veterans in the program. The coordinator said program staff have also worked with staff from the facility's Geriatric and Extended Care and Home-Based Primary Care to meet veterans' healthcare needs, keep many in their homes, and prevent the need for higher levels of care.[81]

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[82] 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.[83]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[84] The facility did not meet the target in FYs 2023 or 2024. The OIG noted the program team consisted of one employee, the Veterans Justice Program Coordinator, who covers two veterans treatment courts, four specialty courts, five prisons, and

[80] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers." "Compensated Work Therapy," Department of Veterans Affairs, accessed May 2, 2025, https://www.va.gov/health/cwt/.

[81] The goal of Geriatric and Extended Care "programs is to prevent or lessen the burden of disability on older, frail, chronically ill patients and their families/caregivers, and to maximize each patient's functional independence." "Patient Care Services, Geriatrics and Extended Care Program," Department of Veterans Affairs, accessed March 13, 2025, https://www.patientcare.va.gov/geriatrics.asp. Home-Based Primary Care "provides long-term primary medical care to chronically ill veterans in their own homes under the coordinated care of an interdisciplinary treatment team." "Patient Care Services, Home-Based Primary Care," Department of Veterans Affairs, accessed March 13, 2025, https://www.patientcare.va.gov/geriatrics.asp.

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

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

[84] 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*.

14 jails in the service area.[85] In an interview, the coordinator reported missing opportunities to enroll veterans because of previously misunderstanding the enrollment criteria. For example, the coordinator enrolled only those veterans who were scheduled to be released from prison within six months but should have enrolled anyone who was incarcerated or participating in treatment courts. After receiving guidance from the VISN Homeless Program Network Coordinator, however, the coordinator has increased enrollments.

The coordinator also described conducting regular in-person and virtual outreach to jails and prisons within the service area, as well as maintaining collaborative relationships with community partners, veterans treatment courts, and local law enforcement. The coordinator also explained partnering with the Veterans Benefits Administration's Legal Administrative Specialist, who accompanies them on prison visits and answers veterans' questions about benefits and helps them fill out claims paperwork.

Meeting Veteran Needs

The program coordinator reported assessing veterans to determine their needs and referring them to appropriate resources, emphasizing that collaboration between VA and community partners such as Disabled American Veterans is crucial to address veterans' needs. For example, a lack of transportation can pose a barrier for some veterans and make it difficult to attend important appointments such as medical visits or court dates. Therefore, staff work with community partners to ensure veterans' transportation needs are met.

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 construction and patient safety, privacy, and test result communication. Leaders have started to implement corrective actions, and completed corrective actions for one recommendation, which the OIG closed (see OIG Recommendations and VA Responses). 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.

[85] Veterans treatment courts "effectively integrate evidence-based substance use disorder treatment, mandatory drug testing, incentives and sanctions, and recovery support services in judicially supervised court settings that have jurisdiction over veterans involved in the justice system who have substance use disorders, including a history of violence and 7 stress disorder as a result of their military service." "Veterans Treatment Court Program, Overview," Department of Justice, accessed May 2, 2025, https://bja.ojp.gov/program/veterans-treatment-court-program/overview.

OIG Recommendations and VA Responses

Recommendation 1

Executive leaders ensure staff post safety risk assessment permits for all construction projects.

_X_ Concur

____ Nonconcur

Target date for completion: April 30, 2026

Director Comments

Contracting Officer Representatives/Construction Safety Officers for each current construction project ensured that risk assessments have been completed and posted at the entrance to each site, and the Project Section Chief has confirmed the postings on August 26, 2025. To ensure sustainment, the Project Section Chief will verify that risk assessments are completed and posted at site entrances during weekly construction safety rounds. This process will continue until 90 percent compliance or better is achieved for six consecutive months. Compliance will be determined using the total number of passed inspections for all projects divided by the total number of inspections for all projects. The results will be reported by the Project Section Chief to the Construction Safety Committee monthly.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Recommendation 2

The Director assigns a member of the executive leadership team as chair of the Construction Safety Committee to oversee safety activities.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Associate Director, a member of the executive leadership team responsible for overseeing construction safety, has been appointed as the Chair of the Construction Safety Committee. The committee charter was updated to reflect this appointment.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

Executive leaders ensure staff install privacy curtains in all exam rooms.

_X_ Concur

____ Nonconcur

Target date for completion: April 30, 2026

Director Comments

Privacy curtains were promptly installed in all Primary Care (PC) exam rooms by the housekeeping staff during the week of the OIG's inspection. Beginning in January 2025, the Housekeeping Supervisor started monthly inspections of the 45 PC exam rooms to ensure the presence of privacy curtains. The objective was to maintain a monthly compliance rate of 95 percent or higher, which was determined by the number of PC exam rooms that had privacy curtains correctly installed out of the 45 total PC rooms observed. These ongoing monthly inspections have successfully achieved 100 percent compliance each month from January 2025 through October 2025. This process will continue until 95 percent compliance or better is achieved and documented for an additional six consecutive months. The Readiness Coordinator will report inspection results to the Quality and Patient Safety Committee quarterly until closure.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Recommendation 4

Executive leaders ensure staff install handrails on both sides of the hallway in the Community Living Center.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2026

Director Comments

On November 7, 2025, facility Engineering staff conducted a survey to identify Community Living Center hallway locations lacking handrails on both sides to determine the materials

needed for this project. This survey determined that the facility has the required materials available to complete the handrail installation and does not necessitate contracting to complete. Material has been gathered, and facility Engineering staff are projected to begin work on the project the week of November 24, 2025. Work is estimated to take approximately four months to complete. The Maintenance & Repair Supervisor is responsible for overseeing this project as described above. The Chief of Engineering will provide quarterly status updates to track progress through the Healthcare Operations and Environment of Care Committee.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Recommendation 5

Executive leaders ensure staff follow the facility's policy for communication of abnormal test results to patients.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2026

Director Comments

The Associate Chief of Staff (ACOS) for Specialty Care, ACOS for Primary Care, Chief Informatics Officer, Administrative Officer to Chief of Staff, Chief of Laboratory Services, and Chief of Quality and Patient Safety are collaborating to implement a standardized auditing system to ensure timely communication of abnormal results to Veterans according to facility policy. The Chief Informatics Officer is optimizing mechanisms to capture abnormal test results data to audit. Pulling test results coded as abnormal and test result letters that have been mailed to patients are two methods being explored and tested. The target date to have data established to begin audits is December 31, 2025. Using this data, the ACOS for Specialty Care, or designee(s), will conduct a monthly chart review of 30 random abnormal test results to assess for compliance with results communication standards. The audit results will be analyzed to help identify areas for improvement with abnormal test results communication and drive corrective actions. Audits will continue as described until a target of 90 percent or greater is achieved for six consecutive months. The compliance rate will be determined by the number of abnormal test results that were communicated to the Veterans according to timeliness standards out of the total number of results audited for the month. Monthly audit results will be reported quarterly to the Quality and Patient Safety Committee by the Readiness Coordinator through closure.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Appendix A: Methodology

Inspection Processes

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

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

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

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from December 3 through 5, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[2] The OIG received responses from two VSOs (the Department of South Dakota Veterans of Foreign Wars and American Legion Post 15).

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

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: October 23, 2025

From: Director, VA Midwest Health Care Network (10N23)

Subj: Healthcare Facility Inspection of the VA Sioux Falls Health Care System in South Dakota

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

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

Thank you for the opportunity to review and comment on the Office of Inspector General Healthcare Facility Inspection of the VA Sioux Falls Health Care System. I concur with the facility and the report as presented.

(Original signed by:)

Judith L. Johnson-Mekota, FACHE
Interim Executive Director
VA Midwest Healthcare Network (VISN 23) Minneapolis, MN

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 23, 2025

From: Director, VA Sioux Falls Health Care System (438)

Subj: Healthcare Facility Inspection of the VA Sioux Falls Health Care System in South Dakota

To: Director, VA Midwest Health Care Network (10N23)

1. Thank you for the opportunity to review and comment on the draft report for the Healthcare Facility Inspection of the VA Sioux Falls Health Care System. I appreciate the review by OIG as part of our commitment to quality and safety through ongoing process improvement.
2. I concur with Recommendations 1-5 outlined in this report. Please see the attached corrective actions for each Recommendation.

(Original signed by:)

Sara S. Ackert, MHA
Executive Director/CEO

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Ayesha Jackson, MSN, RN, Team Leader Simon Kim, PhD Carolyn McKay, MSW, LCSW
Other Contributors	Kevin Arnhold, FACHE Shelby Assad, LCSW Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.