US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Washington DC Healthcare System

Healthcare Facility Inspection	24-00551-64	March 13, 2025

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Washington DC Healthcare System (facility) from April 1 through 4, 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. The OIG found that facility leaders had responded to system shocks over the past few years, which included national changes to VHA's human resources organizational design, staffing limits, and the COVID-19 pandemic.[2] Leaders were working to maintain adequate staffing levels and handle post-pandemic patient discharge challenges. The human resources organizational design had delayed hiring new staff and increased responsibilities of facility administrative staff and service chiefs, as they took on those duties traditionally completed by human resources staff. Updated staffing limits had just been announced at the time of the OIG site visit, leaving leaders to re-evaluate facility-wide hiring needs, including for newly planned primary care teams.

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

[2] Beginning in fiscal years 2019 and 2020, and due to a national human resources staffing shortage, VHA centralized human resource services from the facilities to the Veterans Integrated Services Networks (VISNs) with the intent to standardize processes and make this function more effective. Department of Veterans Affairs HR [Human Resources] Hub, accessed April 10, 2024, https://dvagov.sharepoint.com/vha/HR Modernization. (This website is not publicly accessible.)

The pandemic affected the number of community nursing homes (long-term care) that remained open post pandemic, which limited the number of patients who could be discharged to long-term care and the availability of inpatient beds. Leaders said staff from different departments worked together to address the issue, learn from it, and re-evaluate their processes.

According to employee respondents to an OIG questionnaire, the VA mission was the principal reason for staying at the facility, while stress and burnout were the most common reasons for dissatisfaction. The Director described working toward a psychologically safe environment, sharing an example of nurses feeling comfortable to speak up and prevent employees from performing two separate wrong-site surgical procedures.[3]

Regarding veterans' experiences, OIG questionnaire respondents indicated that veterans' most common complaints involved difficulty scheduling appointments and contacting the care team. The Director said they recently developed a position for a chief experience officer to oversee the process of responding to and resolving complaints.

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 to be clean and well maintained, with parking and a welcoming main entrance. Staff had recently updated interior navigation (directional) signs, and the OIG team was able to navigate the facility easily. The OIG observed multiple public waiting room televisions where closed captioning was not being used and requests facility leaders to consider using it to accommodate veterans with hearing impairments.

During an inspection of transit and parking, the OIG observed the facility entrance was very congested with traffic coming into and out of the facility, and from a large community hospital across the street. While this city street is not on VA property, it does present a concern for safe traffic flow and veterans' ability to safely use crosswalks to get to the facility. The OIG found the crosswalk from the patient parking garage to the main entrance had faded markings, lacked signage, and was missing other recommended safety features. The OIG recommends leaders improve visibility at the crosswalk. The OIG also observed that the driveway at the main entrance was very crowded due to the number of vehicles accessing this area. While the facility

[3] "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.

had set up lanes for pickup and drop-off, as well as for the valet parking service, the OIG noted this area could benefit from some additional traffic management.

In the Emergency Department, the OIG identified multiple blanket warmers that were set to temperatures higher than 130 degrees Fahrenheit and an electrical issue in the department, where a single publicly accessible switch controlled non-emergency power outlets and lights in the area.[4] The OIG made two recommendations.

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 staff had processes for alerting providers about test results and had audited some data related to provider notification. Facility leaders said providers were frustrated with the number of alerts they receive in the electronic health record system but had applied for a grant for an artificial intelligence program to help providers resolve the alerts.

The OIG found that facility staff had not sustained improvement processes for identifying adverse events that could require an institutional disclosure, which was a finding from a prior OIG comprehensive healthcare inspection conducted in August 2021.[5] After analyzing case reviews, the OIG determined staff did not conduct some institutional disclosures when warranted and made a recommendation.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation

[4] "Best practice would utilize evidence-based guidelines and recommendations by organizations such as but not limited to AORN [Association of Perioperative Registered Nurses] and ECRI [Emergency Care Research Institute] determine optimal and safe temperatures for blankets to be warmed to. Both AORN and ECRI recommend [a] maximum temperature setting of 130 degrees Fahrenheit (54 degrees Celsius) for blanket warming cabinets." "The Joint Commission Standards FAQs [frequently asked questions]," The Joint Commission, accessed November 26, 2024, https://www.jointcommission.org/standard-faqs.

[5] An institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. VA OIG, *Comprehensive Healthcare Inspection of the Washington DC VA Medical Center*, Report No. 21-00288-175, June 16, 2022.

affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[6]

The OIG noted the facility's average panel size (the number of patients assigned to primary care teams) exceeded 100 percent from February 2023 through March 2024, meaning some primary care teams were assigned to care for more than the baseline capacity of patients. The facility had an increase in veteran enrollment since fiscal year 2021, which staff said led to the large panel sizes and longer appointment wait times. The OIG also noted several vacancies across the existing teams that leaders were working to fill. Leaders had also approved adding eight new primary care teams but may have to alter this plan because of recent VHA-wide changes to staffing ceilings. Primary care team members reported feeling supported despite an overwhelming workload and staff assignments to multiple teams to cover vacancies.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the facility had active programs with a strong emphasis on outreach and connections with multiple community partners. Program staff described assessing veterans' needs and completing treatment plans that included vocational rehabilitation, substance use treatment, mental health care, and employment service referrals. Staff also collaborate with community partners for veterans who need financial or legal assistance.

Staff said the local Department of Human Services notifies the homeless program team of upcoming encampment closures so they can assist any veterans being displaced. Staff highlighted successfully housing every veteran agreeing to services during the closure of an encampment at McPherson Square.

What the OIG Recommended

The OIG made four recommendations for improvement.

1. Facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalk between the patient parking garage and main entrance until completion.
2. Facility leaders ensure blanket warmer temperatures do not exceed 130 degrees Fahrenheit and implement a process to inform staff about proper use of the equipment.

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

3. Facility leaders implement actions to correct the electrical issue in the Emergency Department Main 2 area and mitigate the risk until it is resolved.
4. Facility leaders reevaluate and improve their processes for identifying adverse events that warrant an institutional disclosure.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Interim Medical Center Director concurred with the recommendations and provided acceptable action plans (see appendixes D and E, and the responses within the body of the report for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 3 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
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
QSV	Quality, Safety, and Value
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organizations

FACILITY IN CONTEXT

VA Washington DC Healthcare System
Washington, DC
Level 1a- High Complexity Level
District of Columbia County
Hospital Referral Region: Washington, DC

Description of Community

POPULATION

Female **2,638,687**	Male **2,508,959**
Veteran Female **47,564**	Veteran Male **268,279**

Homeless - State **4,410**
Homeless Veteran -State **208**

MEDIAN INCOME

$74,242

EDUCATION

91% Completed High School
62% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **230**

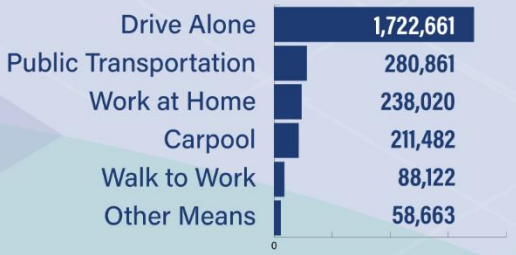
SUBSTANCE USE

27.5% Driving Deaths Involving Alcohol
18.1% Excessive Drinking
1,586 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
3% Veterans Unemployed in Civilian Workforce

TRANSPORTATION



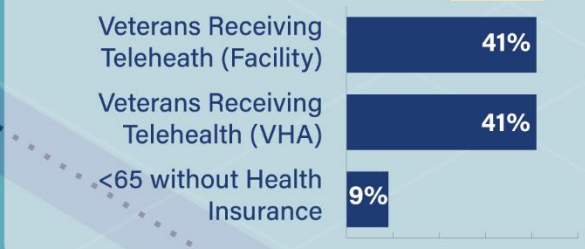
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**20 Minutes, 14 Miles**
Specialty Care	**47.5 Minutes, 38.5 Miles**
Tertiary Care	**79.5 Minutes, 70.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **39,266**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

22,682

339 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.54 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
8	<10 Total

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	110K
Unique Patients VA Care	106K
Unique Patients Non-VA Care	27K

COMMUNITY CARE COSTS

Unique Patient $33,414	Outpatient Visit $343
Line Item $1,283	Bed Day of Care $338

★ VA MEDICAL CENTER

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.18%
Facility Total Loss Rate	11.66%
Facility Retire Rate	2.47%
Facility Quit Rate	7.29%
Facility Termination Rate	1.70%

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

Contents

Background and Vision

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

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

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

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

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

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]

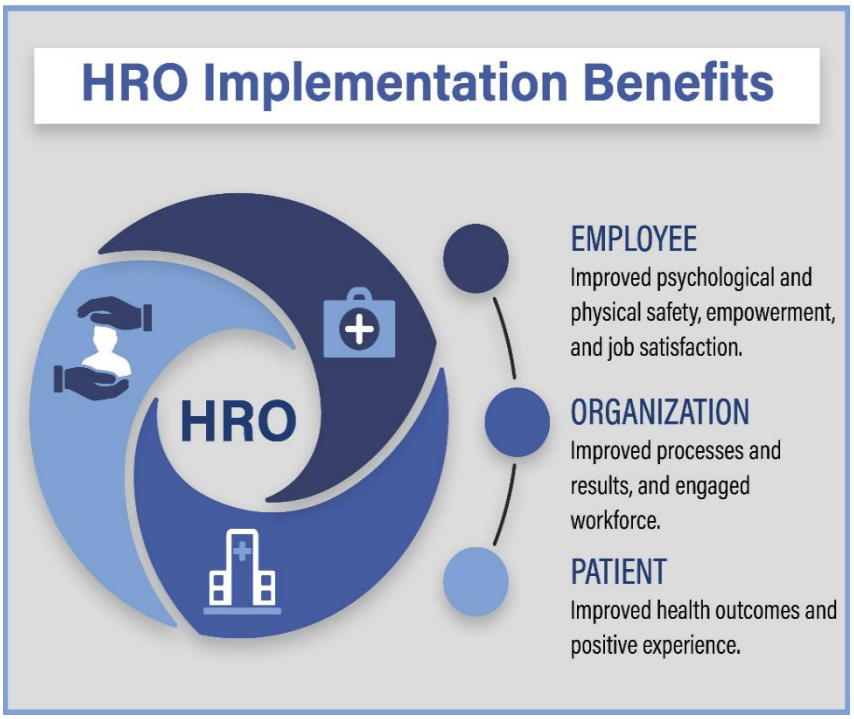


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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]

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

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

PACT Act

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

[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.

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

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

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

[12] "VA PACT Act Performance Dashboard," VA, accessed May 1, 2023, https://www.accesstocare.va.gov/VA_PACTActDashboard.pdf.

Content Domains

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al. "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

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

The Quality Management Coordinator reported the VA Washington DC Healthcare System (facility) opened in 1965. At the time of the inspection, the facility's executive leaders consisted of a Medical Center Director (Director), Deputy Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director of Resources, Associate Director of Operations, and Assistant Director. The newest member of the leadership team, the Associate Director of Operations, was assigned in June 2024. The Director, in place since 2018, and the Chief of Staff, assigned in May 2016, were the most tenured. In fiscal year (FY) 2023, the facility's budget was approximately $999 million.[13] The facility had 285 operating beds, which included 165 hospital and 120 community living center beds.[14]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

[13] This budget number includes approximately $195 million allocated for community care.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 26, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp.

[15] 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.

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

In an interview, the facility's executive leaders discussed some system shocks that affected the organization's culture. The Director identified the realignment of human resources functions under Veterans Integrated Service Network (VISN) responsibility and new staffing ceilings as significant system shocks.[20] The Director reported believing the human resources realignment had an inadequately planned, problematic implementation nationally that led to delayed hiring of new staff while human resources staff transferred from the facility to the VISN. The executive leaders voiced their struggles with the bottleneck created by hiring delays and problems finding a sustainable solution. The Associate Director of Resources said facility service chiefs and administrative staff had taken on responsibilities traditionally done by human resources specialists, in addition to their normal duties, to reduce the impact.

Additionally, the Director stated VHA had just announced updated limits for the number of full-time staff. The Director indicated the facility was above the new ceiling for full-time staff at the time of the notification, leaving leaders to re-evaluate facility-wide hiring needs, including for newly planned primary care teams. The Director further stated the human resources realignment and new staff ceiling would potentially affect patient care and staff burnout.

The ADPCS identified an additional system shock related to patient discharges. The leader explained that many community nursing homes (long-term care) had limited or stopped admitting new patients and subsequently closed because of the COVID-19 pandemic. Staff were then unable to discharge inpatients to long-term care, affecting patients in some areas like the

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

[19] 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*.

[20] Beginning in fiscal years 2019 and 2020 and due to a national human resources staffing shortage, VHA centralized human resource services from the facilities to the Veterans Integrated Service Networks (VISNs) to standardize processes and make this function more effective. Department of Veterans Affairs HR [Human Resources] Hub, accessed April 10, 2024, https://dvagov.sharepoint.com/vha/HR Modernization. (This website is not publicly accessible.) VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

Emergency Department, where they were waiting for available inpatient beds. The leader further stated that staff from different departments worked collaboratively to navigate the change and find ways to address barriers to discharge, taking this system shock as a learning opportunity and reevaluating processes to incorporate best practices and enhance communication.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[22] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]

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

The OIG spoke with executive leaders, who shared their focus on improving communications through town halls, huddles (short meetings to share problems and identify solutions) between leaders and staff, and leadership rounding (visits to staff in their work areas) throughout the organization. For example, the Associate Director of Operations gathered feedback and initiated quarterly town halls that helped improve leaders' communication with staff. The Chief of Staff emphasized the value of huddles as tools to increase executive leaders' visibility with facility staff. The executive leaders also identified some barriers to communication, including the distance to community-based outpatient clinics and lack of dedicated computers for all staff. To minimize these barriers, the Deputy Director described increasing visits to community-based outpatient clinics and providing computers for staff to share so they can view emails and other communication.

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

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

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

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

Employee Experience

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

The Director shared that leaders strive for a psychologically safe environment and gave an example from the surgery department where, on two separate occasions, a nurse identified incorrectly marked surgical locations on the patient's body and prevented employees from performing a wrong-site surgical procedure. The Director attributed this to the nurse feeling psychologically safe to speak up, adding that this showed the process for reporting potential patient care issues worked as expected for employee empowerment and patient safety.

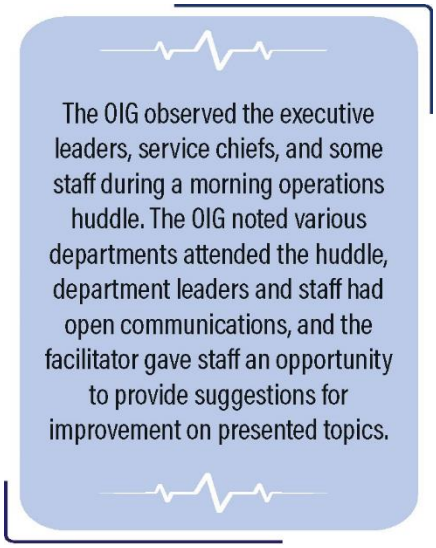


Figure 5. *Morning operations huddle. Source: OIG team observation.*

According to the OIG's questionnaire responses, the VA mission was the principal reason for employee retention, while stress and burnout were the most common reasons for dissatisfaction. Facility leaders provided multiple examples of efforts to improve the employee experience, such as implementing HRO initiatives and servant leadership practices (leaders focus on the growth and well-being of their employees) and expanding training opportunities.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[27] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to

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

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

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

veterans and their families.[28] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

The OIG found the most common veteran complaints involved difficulty scheduling appointments and contacting the care team. However, questionnaire responses indicated that facility leaders provided direct feedback to complainants and responded to concerns received by the patient advocate team and VSOs. The Director stated that more participation and feedback from VSOs would be helpful but acknowledged that was a challenge due to low membership in the area.

The ADPCS highlighted leaders' focus on proactive approaches for improving the veteran experience at the time of service. For example, managers increased face-to-face interactions with veterans by visiting them during their hospitalization to identify and resolve concerns timely. The Director added they recently developed a position for a chief experience officer to oversee all veteran experiences, including customer service recovery (the process of responding to and resolving customer complaints).

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.[29] 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: "Washington VA Medical Center," Department of Veterans Affairs, accessed November 22, 2024, https://www.va.gov/washington-dc-health-care/locations/.

[28] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.
[29] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[30] 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.[31]

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.

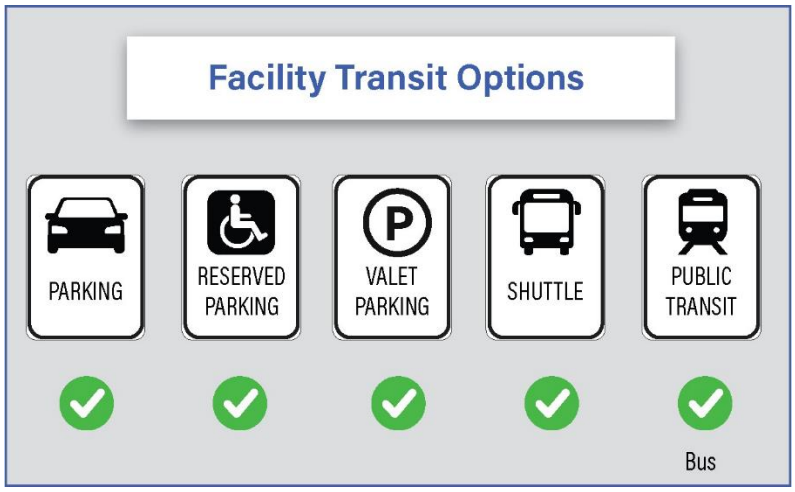


Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG used various internet map options to obtain directions to the facility. The facility had two public entrances to the property, both off First Street Northwest. The intersection near the main entrance had a four-way stop with multiple lanes. The OIG observed traffic congestion in the area, with traffic coming into and out of the facility, and from a large community hospital across the street. While the city street is not on VA property, the OIG is concerned about the traffic and veterans' safe use of crosswalks to get to the facility (see appendix C, figure C.1).

The OIG also found the driveway at the main entrance very crowded, with vehicles either driving through or parked and waiting for passengers. The traffic included shuttles and buses transporting veterans to and from the facility. The OIG noted that it was difficult for veterans to access the main entrance without walking across the busy traffic lanes. The Chief of Police told

[30] 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.

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

the OIG that VA police officers and valet personnel support the flow of traffic at the main entrance, but the OIG did not observe this. While the facility had set up lanes for pick-up and drop-off, as well as for valet parking service, the OIG noted the main entrance driveway area would benefit from additional traffic management (see appendix C, figures C.2–C.5).

The OIG also observed a potential safety issue with the crosswalk between the patient parking garage and main entrance, which had faded street markings, a missing detectable warning surface (feature to alert pedestrians who are visually impaired of a hazard in the line of travel), and lacked signage or a warning system at both sides of the intersection (see appendix C, figure C.6). Per the VA Site Design Manual, crosswalks are to be marked with "clearly visible painted stripes or by street paving that is consistent with walkway paving material," detectable warning surfaces, and adequate street lighting.[32] The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalk between the patient parking garage and main entrance until completion.

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.[33]

The OIG found limited exterior signage directing veterans to the facility. The signage appeared weathered in general, and a large sign on the corner of First Avenue Northwest and Irving Street lacked illumination for visibility in the dark. The facility Interior Designer informed the OIG that a project proposal to update the exterior signage was awaiting funding.

The OIG noted the entrance had power-assisted doors with access ramps and physical assistance devices, such as wheelchairs, available just beyond the door. The OIG also observed that contracted security personnel immediately welcomed veterans and requested identification. The entrance was well-lit and clean, and the area included an information desk, ample seating, and a coffee shop.

[32] VA Office of Construction and Facilities Management, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

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

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.[34]

The OIG noted the main lobby's information desk staff provided printed maps on request to assist veterans in navigating the facility, but no mobile application was available. The OIG inspectors found their way around using the facility's navigational cues and wall directories, which the Interior Designer said were recently updated (see appendix C, figures C.7 and C.8).

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The OIG did not identify complaints to the patient advocates about a lack of navigation aids for veterans with impaired vision or hearing. During the walk-through inspection, the OIG found braille and auditory cues in elevators and at door entrances. The OIG determined information desk staff were not able to communicate using basic sign language, but the staff explained they have used phone text features to communicate when needed. The OIG spoke to a visually impaired veteran who reported getting support from facility staff when encountering challenges navigating the facility.

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

The OIG observed the main lobby did not offer a sound buffering method to improve the experience for hearing-impaired individuals; however, the Interior Designer discussed looking into costs for potential future projects. Further, the OIG observed multiple public waiting rooms had televisions without closed captioning in use

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

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

to accommodate the hearing-impaired veterans. The OIG requests that facility leaders consider using closed captioning on televisions in common areas.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[36]

The OIG inspection team easily identified the toxic exposure screening navigators' location on the facility map. The navigators' clinic area was in the Comprehensive Assessment of Respiratory and other Military Exposures (CARE) Center. The center had sufficient space for the navigators to conduct walk-in screenings, and veterans had access to several informational handouts in multiple languages explaining the PACT Act. During an OIG interview, a navigator described conducting outreach, like sending a postcard to veterans with upcoming appointments that prompts them to follow up with their provider to complete initial screenings. Additionally, a navigator shared that facility staff received training on the importance of completing screenings during veterans' care visits.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[37] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG found that in FY 2023, facility staff did not meet VHA's target metric of 90 percent for closing identified environment of care deficiencies or having an action plan to address them within 14 business days; however, facility leaders did consistently attend environment of care rounds.[38] In an interview, the Associate Director of Resources reported that the chief of safety position was vacant for an extended period, which contributed to delays in closing deficiencies.

---

[36] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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

[38] The facility's compliance rate for closing identified deficiencies within 14 business days was approximately 74 percent. Acting Deputy Assistant Under Secretary for Health for Operations, "Fiscal Year (FY) 2023 Comprehensive Environment of Care (CEOC) Guidance (VIEWS 9547420)," memorandum to Veterans Integrated Service (VISN) Directors, February 21, 2023.

The OIG found that, overall, the facility was clean and well maintained and therefore did not make a recommendation.

The OIG reviewed the patient advocate report and found that a veteran submitted a concern in October 2023, pointing out that a single electrical switch at the entrance to the Emergency Department's Main 2 area controlled electricity to the entire clinical area. The Energy Manager reported being unaware of the issue, but confirmed this did not affect the red emergency outlets (used for critical equipment and powered by the generator system in the event of an electrical outage). During the initial inspection, the OIG found staff had placed a plastic cover over the switch with a note asking that no one turn it off. The OIG returned to the area during the inspection week and found that Facilities Management Service staff had not resolved the issue but had removed the plastic cover. Having a single switch control the electricity to an area accessible to anyone risks a disruption of power to noncritical equipment, computers, and lighting needed to support patient care in the area. The OIG recommends facility leaders implement actions to correct the electrical issue in the Emergency Department Main 2 area and mitigate the risk until it is resolved.

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 several clinical areas and found them clean and well maintained.[39] In the Emergency Department, however, the OIG found multiple blanket warmers set to high temperatures which could lead to patient injuries. Following this finding, staff reported taking one blanket warmer out of service and setting the temperature for the rest to 130 degrees Fahrenheit.[40] Also, staff had begun working on a process to address the blanket warmers throughout the organization. The OIG recommends facility leaders ensure blanket warmer temperatures do not exceed 130 degrees Fahrenheit and implement a process to inform staff about proper use of the equipment.

[39] The OIG inspected the Emergency Department, outpatient clinic, community living center, and medical and surgical inpatient areas, including a critical care unit.

[40] "Best practice would utilize evidence-based guidelines and recommendations by organizations such as but not limited to AORN [Association of Perioperative Registered Nurses] and ECRI [Emergency Care Research Institute] to determine optimal and safe temperatures for blankets to be warmed to. Both AORN and ECRI recommend [a] maximum temperature setting of 130 degrees Fahrenheit (54 degrees Celsius) for blanket warming cabinets." "The Joint Commission Standards FAQs [frequently asked questions]," The Joint Commission, accessed November 26, 2024, https://www.jointcommission.org/standards/standard-faqs.

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.[41] 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.[42] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The Chief of Staff explained staff were developing a policy to comply with the July 2023 update to VHA Directive 1088, which allowed facilities 6 to 12 months to create a local policy with service-level workflows that describe the team member roles in the process for communicating test results to providers and patients.[43] The Chief of Quality, Safety, and Value (QSV) explained that, in the interim, facility staff relied on the directive and service-level standard operating procedures for guidance on communicating test results, such as time frames for reporting urgent laboratory results to ordering providers.

The Deputy Chief of QSV described ongoing efforts to improve communication of test results within 7 days and improvements staff had made for communicating test results within 30 days, as evidenced by two external peer review program metrics. Those improvements resulted from QSV staff working with different stakeholders to evaluate test result communication as part of their chart audit processes.

During an interview, facility leaders stated that for test results requiring action, the electronic health record system automatically alerts the ordering provider, or a designee if the ordering provider is unavailable. However, the OIG noted the process depended on an ordering provider or an informatics employee assigning a designee for the system to work properly. The Chief of

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

[42] 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.

[43] VHA Directive 1088(1).

Radiology and the Chief of Pathology and Laboratory Medicine added that critical or urgent results generate alerts automatically, but radiology and laboratory staff also report them directly to the ordering provider, surrogate provider, or service chief following time frames outlined in the standard operating procedures.

Facility leaders shared that providers had expressed frustration with high numbers of alerts related to test results. Further, staff could not alter some system-level settings (settings managed by national VHA programs), which control the events that generate alerts and limit local customization options to reduce the number of alerts providers receive. The Chief of Staff described looking for innovative solutions to this issue. For example, staff had recently applied for a grant for an artificial intelligence program that could help providers resolve electronic health record system alerts and transcribe provider and patient interactions. The Chief of Staff expressed optimism that such innovative techniques could effectively reduce the burden of the large number of alerts in the future.

Action Plan Implementation and Sustainability

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

An OIG comprehensive healthcare inspection conducted in August 2021 resulted in a recommendation about sentinel events and associated institutional disclosures; a similar finding during this OIG inspection indicated facility staff had not sustained prior improvement actions.[45] VHA requires facility leaders to perform an institutional disclosure for adverse events "that resulted in, or reasonably expected to result in, death or serious injury and provide specific information about the patient's rights and recourse."[46] The OIG found leaders did not conduct institutional disclosures for some adverse events where delays in diagnosis or care may have contributed to patient death or could have resulted in serious injury and were unable to explain

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

[45] "A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)." The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), January 2024; An institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018; VA OIG, *Comprehensive Healthcare Inspection of the Washington DC VA Medical Center*, Report No. 21- 00288-175, June 16, 2022.

[46] VHA Directive 1004.08.

why they did not conduct them. The OIG recommends facility leaders reevaluate and improve their processes for identifying adverse events that warrant an institutional disclosure.

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.[47] 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.[48] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Chief of Pathology and Laboratory Medicine reported a trend in patient safety reports associated with specimen labeling that prompted a facility-wide quality improvement project. The project involved the creation of posters showing proper specimen labeling, sessions to train staff, and updates to specimen ordering processes in the electronic health record system.

The Chief of Staff described the facility's continuous learning process as starting with morning operations huddles for facility and service-level leaders, including QSV staff such as the Patient Safety Manager, who bring up identified deficiencies, discuss actions to address the deficiencies, and disseminate lessons learned. The Chief of Radiology stated that huddle participants further disseminate the information on deficiencies, actions, and lessons learned through smaller service-level huddles to perpetuate continuous learning.

The Chief of Staff and Deputy Chief of QSV acknowledged there were opportunities for the QSV Executive Council to improve how it tracked action items and process improvement initiatives until they were completed. For example, the Deputy Chief of QSV reported council members did not consistently review the action item tracker for progress or sustainability, although this review was a standing agenda item. The Deputy Chief of QSV added that QSV staff had competing demands, partly because the department's administrative support position had been vacant for the past year.

[47] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[48] VHA Directive 1050.01(1).

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[49] 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.[50] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[51] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, the Chief of Primary Care reported the facility had 64 primary care teams. Additionally, the chief shared that 8 new teams had been approved but not yet established. As discussed in the Culture section, the recent change to the facility's staffing ceiling might affect the implementation of the new teams. For the existing teams, facility documentation itemized the following vacancies: 32 medical support assistant, 23 licensed practical nurse, 15 registered nurse, and 9 primary care provider positions. Vacancies reported for the approved new teams were 5 medical support assistant, 7 licensed practical nurse, 7 registered nurse, and 8 primary care provider positions.

While primary care team positions had vacancies, leaders explained that licensed practical nurse and medical support assistant positions were the most difficult to fill. Leaders added that recruiting licensed practical nurses was difficult because VHA's pay scale had been lower than in the private sector, so they recently increased the pay and offered other recruitment and retention incentives for the position. The Deputy Chief Business Office said leaders also applied a higher special salary rate for medical support assistants, adding that retaining these assistants was challenging because the positions were generally entry level, the work could be stressful, and some employees would transfer to other government agencies in less demanding positions.

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

[50] 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).

[51] 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 Deputy Chief Business Office stated there were several medical support assistants in training at the time of the OIG inspection, with additional positions scheduled to be advertised. The Chief of Primary Care and ADPCS mentioned that although they had vacancies for primary care physicians and registered nurses, they had no difficulty recruiting in the local area.

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.[52] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[53]

The OIG found that primary care team staffing shortages affected panel size. The average panel size across teams had exceeded 100 percent from February 2023 through March 2024, meaning some primary care teams were assigned more than the baseline capacity of 1,200 patients. In addition, when discussing panel size and staffing shortages, the Chief of Primary Care explained that leaders assigned designees for providers' planned and unplanned absences when needed, but designees lacked sufficient administrative time, as they also managed their own panels. The chief added that leaders were working to arrange additional administrative time for providers acting as designees for more than three days.

The OIG found there was a 2.48 percent increase in veteran enrollment at the facility since FY 2021, as well as longer appointment wait times. The Deputy Chief Business Office attributed these increases to a growing number of veteran retirees in the area rather than implementation of the PACT Act. Primary care staff said the increased enrollments also contributed to the excessive panel sizes and longer appointment wait times. The OIG acknowledged that facility leaders planned to support primary care staff with the addition of eight new teams. However, at the time of the site visit, leaders were working through a new VHA-wide staffing ceiling to determine how they were going to meet facility goals and needs.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[54] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements. The OIG interviewed representatives for each of the primary care team roles. Those interviewed, as well as the ADPCS and Chief of Primary Care, identified staff vacancies and the patient scheduling system as the major issues affecting efficiency.

[52] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[53] VHA Directive 1406(1).

[54] VHA Handbook 1101.10(2).

Primary care staff stated their workload was increasing and they felt overwhelmed because of assignments to cover vacant positions on multiple teams. The staff also stated they believed their facility leaders were supportive and aware of the difficulties filling the position vacancies. The ADPCS added that leaders addressed staff burnout by providing wellness information in town halls, emails, and meetings.

Additionally, facility leaders described a lack of office space to accommodate primary care staffing needs. To help alleviate the space issue, the Chief of Primary Care stated they were increasing telework days for clinical staff, while the Deputy Chief Business Office reported using office space in another part of the facility.[55]

Staff said the patient scheduling system, which the VISN implemented about a year ago, created additional work for the primary care teams. For example, when patients call for appointments, instead of scheduling the appointments, VISN patient scheduling staff route the requests to facility patient care staff for booking. This process can be inefficient and lead to scheduling delays, and leaders reported the VISN was working to improve the system.

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. After interviewing executive and primary care leaders, the OIG determined veteran enrollment had increased, but the day-to-day work of staff completing toxic exposure screenings did not affect primary care delivery. As previously discussed, the OIG found that facility leaders planned to address increased veteran enrollment but were reevaluating the plan due to recent changes to the staffing ceiling.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better

[55] The site visit occurred in April 2024, which pre-dates the Return to In-Person Work Presidential Memorandum. Return to In-Person Work, Memorandum for the Heads of Executive Departments and Agencies, January 20, 2025, 90 Fed. Reg. 8251 (Jan. 28, 2025). The OIG cannot comment on VA's plan of action to comply with the Presidential Memorandum.

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.[56]

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).[57] 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."[58]

The facility's HCHV program did not meet the performance measure target for FYs 2021 through 2023; however, scores had improved each year. The HCHV Program Coordinator reported that although the number of homeless veterans in Washington, DC, had dropped by 50 percent since 2017, program enrollment rates remained challenging because each month, staff admitted nearly the same number of veterans as those discharged. The coordinator reported the constant influx of enrollees was due, in part, to the city's right-to-shelter approach, which means individuals seeking shelter do not need to prove legal residency.

The HCHV program assisted eligible facility providers to seek approval for the Washington D.C.'s Elderly and Persons with Physical Disabilities Medicaid Waiver Program. HCHV staff reported facility-approved providers can complete assessments for the waiver program that provides assisted living homes for homeless veterans in need of more supportive care. HCHV staff stated the program had about four or five new assisted living homes that provided supportive services for elderly veterans and those with disabilities.

Figure 10. *Best practice for veteran engagement.*
Source: OIG interviews.

The coordinator discussed efforts to meet the target, including working with the VISN Homeless Coordinator six months previously to analyze the facility's recorded program data; they discovered staff had made documentation errors in the national database that affected the metric because they misunderstood data definitions used in the system. The program coordinator told the OIG that staff had received clarification about database criteria to ensure accuracy in documentation. In addition, staff stated the program had received two

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

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

[58] 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.asp.

additional outreach social workers in September 2023, which increased the team's capacity to engage and enroll veterans.

In addition, the coordinator explained that veterans' willingness to engage with the VA homeless programs affects the HCHV5 metric. For example, facility staff and community homeless outreach agencies were aware of about 40 veterans experiencing homelessness, transiency, and issues related to mental health and substance use who had chosen not to engage with the program.

HCHV program staff reported they cover 11 counties and partner with nine continuum of care organizations that work with veterans in the community who would not normally reach out to the VA.[59] Program staff said they receive additional referrals from facility provider consults, informal staff contacts, family members, community outreach, VA's National Call Center for Homeless Veterans, and veterans who refer themselves.[60] Program staff identified visits to the DC Public Library as one of their regular community outreach routes. Through this relationship, library staff often notify them about a homeless veteran on-site, and they make an additional stop. Office staff from another community partner, the local Department of Human Services, notifies the HCHV team of upcoming encampment closures so they can be present to help any veteran being displaced. Staff reported successfully housing every veteran agreeing to services during the closure of an encampment at McPherson Square.

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).[61]

Although the facility met the HCHV1 target each year, program staff explained that fluctuation in the number of discharges to permanent housing depended partly on other programs. For example, in November and December 2023, a community transitional housing program and a local public housing authority temporarily stopped veteran admissions because of understaffing, which limited housing options. In addition, staff said there were generally a lower number of

[59] "The Continuum of Care (CoC) Program (24 CFR part 578) is designed to promote community-wide commitment to the goal of ending homelessness." "Continuum of Care Program," Department of Housing and Urban Development, accessed April 18, 2024, https://www.hud.gov/program_offices/comm_planning/coc.

[60] "Veterans who are homeless or at risk of homelessness—and their family members, friends and supporters—can make the call to or chat online with the National Call Center for Homeless Veterans, where trained counselors are ready to talk confidentially 24 hours a day, 7 days a week." "National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed April 18, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

[61] 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*.

housing options available during winter months, and they relied on help from community partners, such as shelters allowing veterans to extend their stays. Program staff also stated they maintain, update, and send a list of community resources, points of contacts, and program openings weekly to staff in other facility homeless programs such as the Housing and Urban Development–Veterans Affairs Supportive Housing program.

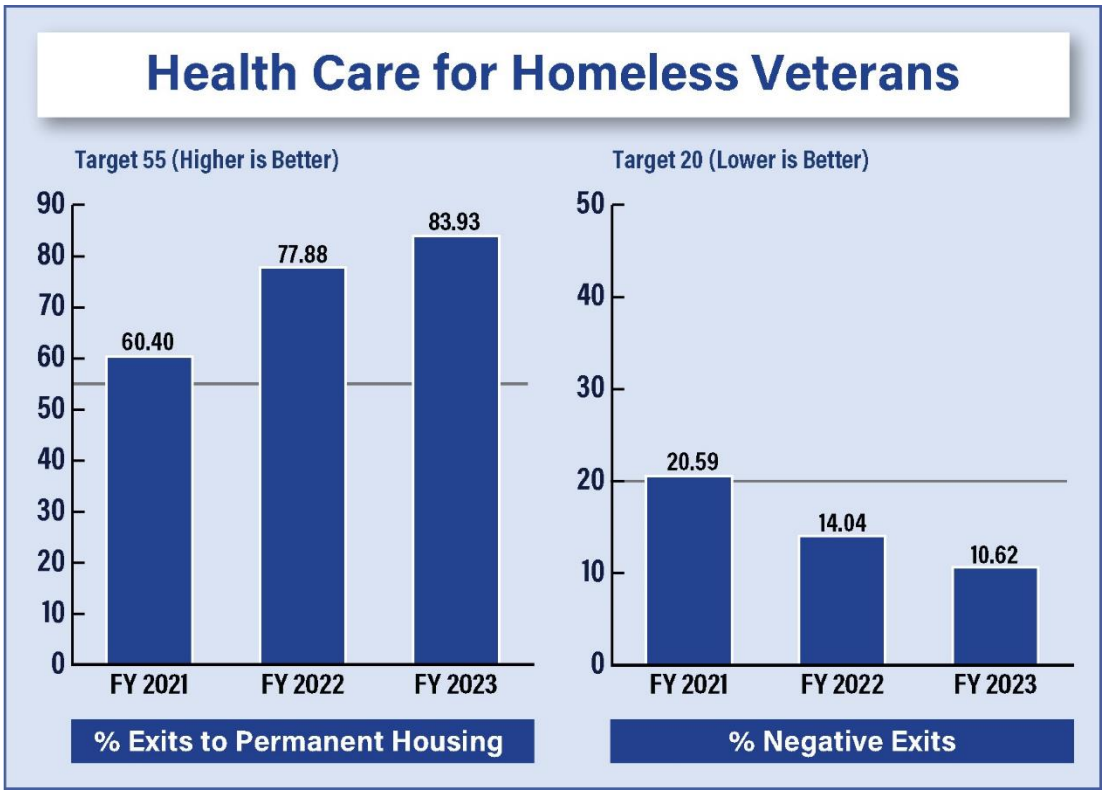


Figure 11. *HCHV program performance measures.*
Source: OIG analysis of VHA Homeless Performance Measures data.

HCHV staff explained their focus is on finding the veteran a safe place to stay first, then initiating support services such as employment, legal and financial assistance, permanent housing, and health care. Staff also explained the work they do to support placement for permanent housing when referring veterans to the Housing and Urban Development–Veterans Affairs Supportive Housing program, such as helping them obtain lost identification and other personal information or connecting them to other agencies for rental assistance or security deposits.

HCHV staff reported enrollment often starts with working with veterans to get them initially engaged and familiar with VA homeless programs and helping them with their wants or needs. Staff shared an example of a homeless veteran who was not interested in program services, including housing. The veteran had a foot problem and, after several HCHV staff outreach visits, agreed to have a facility medical provider conduct a health visit where the veteran was currently living in the community, which program staff coordinated.

Figure 12. *Facility's current community partnerships.*
Source: OIG analysis of a document.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[62] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[63]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[64] The program exceeded the performance measure target in FY 2023. However, the Veterans Justice Program Coordinator discussed a decline in the performance measure in FY 2024, partly because some staff were not available to enroll veterans

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

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

[64] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

in the program because they were on extended leave. At the time of the OIG visit, the program coordinator reported there was now a staffing coverage plan in place.

One staff member reported the program began at the facility in 2009, and since inception, they had established many positive working relationships with jail and prison staff in their service area. The program coordinator stated staff conducted program outreach with courts, attorneys, and probation officers. The program staff member said they received referrals through various means, such as telephone calls from veterans, family members, and defense attorneys. Additionally, staff participated in community resource fairs and provided targeted outreach in jails and prisons to engage veterans in the program.

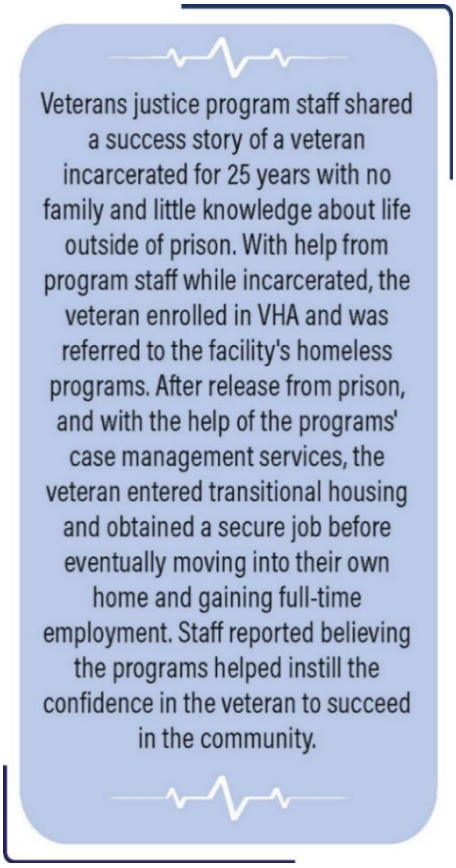


Figure 143. *Veteran success story. Source: OIG interview.*

Meeting Veteran Needs

A program staff member stated staff work with veterans in court settings by connecting them to court-ordered mental health or substance use treatment. There were veteran treatment courts in the Washington, DC, service area, located in Prince William, Fairfax, Loudon, and Prince George's counties.[65] The facility Director told the OIG that more veteran treatment courts were needed to help veterans with their unique needs. Program staff also work with veterans in jails and prisons and after release to help them readjust to community life and prevent homelessness.

Veterans Justice Program staff reported they assess veterans to determine their needs, then complete treatment plans that include referrals to facility case management services, facility primary care, the Housing and Urban Development–Veterans Affairs Supportive Housing program, vocational rehabilitation, substance use treatment, mental health services, and employment services. Program staff rely on community partners for resources for veterans, such as financial or legal assistance.

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

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."[66] 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.[67]

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).[68] The program did not meet the target for FYs 2021 through 2023. The coordinators told the OIG that a barrier to meeting the target was working with eight public housing authorities with different approval procedures and applications could take up to six months to process, thereby delaying a veteran's housing.

A coordinator stated turnover at the public housing authority was an additional challenge because new employees did not understand the application flexibilities afforded to veterans. Further, the coordinator shared an incident in FY 2022 when a public housing authority employee accepted program vouchers for 12 veterans, then mistakenly placed the veterans in a different voucher program that made them ineligible for housing the following year. Fortunately, the housing authority employee corrected the mistake, and the veterans did not lose their housing. To improve communication and prevent similar issues in the future, VHA held Housing and Urban Development–Veterans Affairs Supportive Housing program boot camps in August 2023 and March 2024 with community stakeholders.

Additionally, the coordinators said errors in inputting dates of admissions and discharges affected the performance measure. After discovering the errors, program leaders assigned a staff member to correct identified issues and designated team leaders to enter admission and discharge data into the database.

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

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

[68] 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*.

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).[69] The OIG found the program met the target in FY 2022. However, in FY 2023, the program fell below the target in the third and fourth quarters. One program coordinator explained the program's employment development specialist resigned in July 2023, but leaders did not fill the position until December 2023. This coordinator said the new specialist would help increase the number of housed veterans who are employed. The coordinators added that when staff enroll a veteran, they complete an assessment and develop an individual care plan that includes employment resources, which helps support meeting the metric.

Conclusion

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

[69] 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*.

OIG Recommendations and VA Responses

Finding: The OIG observed a potential safety issue with the crosswalk between the patient parking garage and the main entrance, which had faded street markings, a missing detectable warning surface (feature to alert pedestrians who are visually impaired of a hazard in the line of travel) and lacked signage or a warning system at both sides of the intersection (see appendix C, figure C.6).

Recommendation 1

The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalk between the patient parking garage and main entrance until completion.

__X__ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Associate Director of Operations, Chief and Deputy Chief of Police Services, Acting Chief of Facilities Management, and the facility's Interior Designer met to review this recommendation. The Deputy Chief of Police Services performed a visual inspection of the crosswalk between the main entrance and the parking garage, confirming inadequate detectable warning surfaces. Only one surface is currently installed on the facility-side of the crosswalk. The DC VAMC has taken two actions to improve visibility by refreshed painting of crosswalk lines, performed by the Facilities Management Service, and by solar-powered, flashing stop signs alerting traffic at the intersection. The facility will take steps to ensure the crosswalk meets the guidance of the VA Site Design Manual by installing the missing detectable warning surface.

Finding: The OIG found multiple blanket warmers set to high temperatures which could lead to patient injuries.

Recommendation 2

The OIG recommends facility leaders ensure blanket warmer temperatures do not exceed 130 degrees Fahrenheit and implement a process to inform staff about proper use of the equipment.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

At the time of the identified patient safety event, the facility's Associate Director of Patient Care Services, the Acting Chief Facilities Management Service, Chief of Healthcare Technology Management, and the Deputy Chief of Quality and Patient Safety, coordinated an immediate response, rounding on all units, ensuring devices were compliant to manufacturer's instructions for use. The Associate Director of Patient Care Services implemented signage notifying staff of safe temperature requirements and a compliance log, completed by area nurse management. To support ongoing adoption of these safety practices, the facility will document a standard operating procedure for the proper use of blanket warmers. All facility blanket warmers will be inspected quarterly by area leadership to confirm temperatures do not exceed 130 degrees Fahrenheit. These actions will be tracked in the Quality and Patient Safety Executive Council until 90% compliance to temperature requirements are maintained for two consecutive quarters.

Finding: The OIG found a single electrical switch at the entrance to the Emergency Department's Main 2 area controlled the electricity to the entire clinical area, except for the red emergency outlets, which are used for critical equipment and powered by the generator system in the event of an electrical outage.

Recommendation 3

The OIG recommends facility leaders implement actions to correct the electrical issue in the Emergency Department Main 2 area and mitigate the risk until it is resolved.

__X__Concur

____Nonconcur

Target date for completion: Completed

Director Comments

The Acting Chief of Facilities Management Services, the Supervisory Electrician, the Chief of Emergency Medicine, and the Emergency Department Nurse Manager were made aware of this issue during the active site visit, specifically the impact of the main light switch on non-emergency outlets in the area, a small "fast-track" annex to the Emergency Department including five patient care rooms and a small nurse's station. The Nurse Manager, with Facilities Management Services, inspected the switch and immediately removed the unapproved temporary plastic cover. Once briefed on the finding, the Acting Chief of Facilities Management directed the Supervisory Electrician to address the wiring and to disconnect the switch from the circuit to prevent any disruption of power to equipment required for patient care. This solution was completed immediately following the inspection and verified by the Chief of Emergency Medicine on December 30, 2024. The facility would like to request closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Finding: The OIG found leaders did not conduct institutional disclosures for some adverse events where delays in diagnosis or care may have contributed to patient death or could have resulted in serious injury. This was a similar finding from a previous OIG comprehensive healthcare inspection, indicating staff have not sustained prior improvements.

Recommendation 4

The OIG recommends facility leaders reevaluate and improve their processes for identifying adverse events that warrant an institutional disclosure.

__X__ Concur

____ Nonconcur

Target date for completion: June 30, 2025

Director Comments

The Director reviewed the recommendation and determined no additional reasons for noncompliance. The Risk Manager, Patient Safety Manager, Chief of Quality Management, Clinical Executive Leadership and Medical Center Director or designee meet at least weekly to discuss all Sentinel Events to include cross-checking with Joint Patient Safety Reports to validate that all sentinel events were discussed, and to identify possible institutional disclosures. A summary of each Sentinel Event decision discussion is maintained by the Risk Manager. The Risk Manager will add to the quarterly report on institutional disclosures to the Quality and Patient Safety Committee, co-chaired by the Medical Patient Safety Committee of the number of sentinel events determined to require an institutional disclosure (denominator) and the number of institutional disclosures conducted (numerator).

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 1 through 4, 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 five VSOs (Masonic Service Association, American Legion Auxiliary-Unit 8, Knights of Columbus, VFW Auxiliary, and WAC Vets Association) based on VA's statement that "VA works most closely with [these organizations]." VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/opa/docs/remediation-required/veo/traditionalVeteranOrganizations.pdf.

[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: Facility Pictures

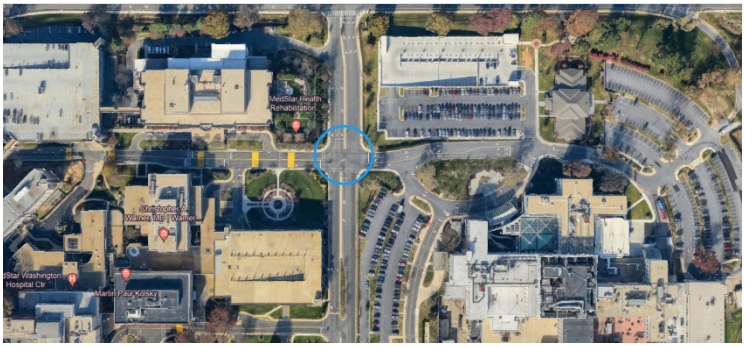


Figure C.1. *Intersection with a four-way stop.*
Source:https://earth.google.com/web/search/Washington+DC+VA+Medical+Center (accessed May 6, 2024).

Figure C.2. *Main entrance.*
Source:https://earth.google.com/web/search/Washington+DC+VA+Medical+Center (accessed May 6, 2024).

Figure C.3. *Driveway to main entrance.*
Source: Photo taken by OIG inspector.

Figure C.4. *Start of driveway to main entrance.*
Source: Photo taken by OIG inspector.

Figure C.5. *Bus stop at end of driveway at main entrance.*
Source: Photo taken by OIG inspector.

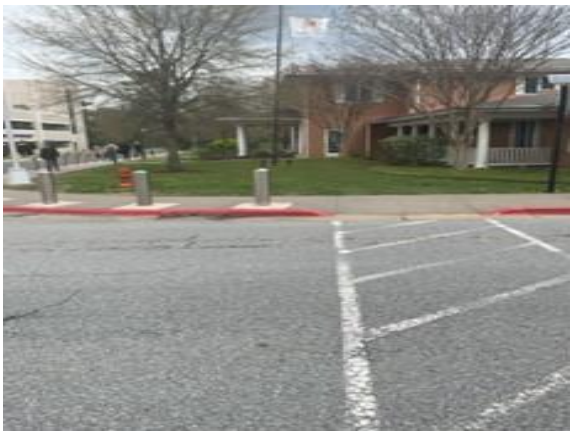


Figure C.6. *Crosswalk to patient parking garage.*
Source: Photo taken by OIG inspector.

Figure C.7. *Example of facility wall directories.*
Source: Photo taken by OIG inspector.

Figure C.8. *Example of facility navigational cues.*
Source: Photo taken by OIG Inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 15, 2025

From: Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Facility Inspection of the VA Washington DC Healthcare System

To: Director, Office of Healthcare Inspections (54HF03)

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

1. I have reviewed and concur with the draft report concerning the Office of Inspector General's (OIG) Healthcare Facility Inspection of the VA Washington DC Healthcare System.
2. I concur with the facility's ongoing corrective actions for recommendations #1, 2, and 4.
3. Recommendation #3 is requested for closure.
4. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 5 Quality Management.

(Original signed by:)

Mark A. Kobelja, M.D.
Chief Medical Officer, VA Capital Health Care Network
for
Robert M. Walton, FACHE
Director, VA Capital Health Care Network

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 30, 2024

From: Director, Washington DC VA Medical Center (688)

Subj: Healthcare Facility Inspection of the VA Washington DC Healthcare System

To: Director, VA Capitol Health Care Network (10N5)

1. Thank you for the opportunity to review and respond to the draft report from the Healthcare Facility Inspection of the VA Washington DC Healthcare System performed in April 2024. I have reviewed the report and concur with all findings and recommendations as written.
2. Attached are the facility responses to the four (4) recommendations, including actions that are in progress to correct the identified opportunities for improvement. The facility would like to request closure of one (1) recommendation, Recommendation three, which was addressed immediately following the inspection.

   (Original signed by:)

   Vamsee Potluri, MBA/MHA, FACHE
   Interim Medical Center Director

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	Jonathan Hartsell, LCSW, MSW, Team Leader Erin Allman, MSN, RN Holly Bahrenburg, BS, DC Kimberley De La Cerda, MSN, RN Donna Murray, MSN, RN Lauren Olstad, LCSW, MSW Estelle Schwarz, MBA, RN Kristie van Gaalen, BSN, RN Michelle Wilt, MBA, RN
Other Contributors	Kevin Arnhold, FACHE Shelby Assad, LCSW Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Brandon LeFlore-Nemeth, MBA Amy McCarthy, JD Scott McGrath, BS Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS David Vibe, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 5: VA Capitol Health Care Network
Director, VA Washington DC Healthcare System (688)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  Maryland: Angela Alsobrooks, Chris Van Hollen
  Virginia: Tim Kaine, Mark R. Warner
US House of Representatives
  District of Columbia: Eleanor Holmes Norton
  Maryland: Andy Harris, Steny Hoyer, Glenn Ivey, April McClain Delaney, Jamie Raskin
  Virginia: Don Beyer, Gerry Connolly, John McGuire, Suhas Subramanyam, Eugene Vindman, Rob Wittman

OIG reports are available at www.vaoig.gov.

Pursuant to Pub. L. 117-263, section 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.