US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia

Healthcare Facility Inspection	24-00603-86	March 26, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Hampton Healthcare System (facility) from August 19 through 21, 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. During the OIG interviews, executive leaders discussed recent system shocks as leadership turnover, growth in the veteran population, and new clinic infrastructure.

At the time of the OIG site visit, the Director served in an acting capacity and was assigned from another VHA facility. About a month before the visit, the Veterans Integrated Service Network Director removed the prior Director from the position, pending an investigation, and the Chief of Staff and Chief of Surgery had stepped down.[2] Additionally, the facility had only two anesthesiologists and one of them resigned and left the facility the week of OIG's inspection.[3]

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

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

[3] An anesthesiologist as a physician "who has special training in giving drugs or other agents to prevent or relieve pain during surgery of other procedures." "Anesthesiologist," National Institutes of Health, National Cancer Institute, accessed February 6, 2025, https://www.cancer.gov/terms/anesthesiologist.

Although leaders had plans to mitigate the shortage of anesthesiologists, they closed the endoscopy area and perform urgent endoscopy procedures in the operating room.[4]

Additionally, facility leaders discussed growth in veteran enrollment. To accommodate the increased enrollment, leaders plan to open two new clinics in 2025 in the Chesapeake and Norfolk areas. These clinics will provide health care on the south side of the service area, where approximately 60 percent of the veterans live, for the first time in the facility's history.

The Chief of Patient Experience mentioned the three most common complaints from veterans were provider communication and appointment scheduling delays, and billing from care received in the community.[5] The lead patient advocate explained that assigned advocates may not have time to adequately resolve veterans' complaints because they have other duties, service leaders often did not respond to complaints timely, and executive leaders did not sufficiently intervene when needed. The Acting Director reported setting an expectation for staff and leaders to adequately address the complaints in a timely manner.

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 whether there were recurring issues.

The OIG confirmed trends from patient advocate reports about parking and clinic opening procedures. The OIG found parking signs did not clearly identify patient versus staff use and lacked directions to parking areas close to specific departments and services. Additionally, the OIG noted there was no valet parking, the shuttle service lacked a schedule and pick-up locations, and the OIG did not see any phones or signs with a phone number for veterans to call the shuttle.

The OIG also observed aisles between accessible parking spaces, which provide an area for veterans with mobility impairments to exit and enter their vehicles, had faded pavement markings and cars parked in them. Further, crosswalks had faded road markings, missing detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel), poor street lighting, and absent crosswalk signs or auditory and visual warning

[4] In endoscopy procedures, healthcare providers use a scope to examine organs or areas inside the body. "Endoscopy," Cleveland Clinic, accessed October 18, 2024, https://my.clevelandclinic.org/diagnostics/endoscopy.

[5] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed November 21, 2024, https://www.va.gov/communitycare/.

systems.[6] The OIG issued two recommendations for leaders to improve accessible parking spaces and crosswalks.

At the main entrance, the OIG observed there were two swinging doors with push-button access that appeared to be on a timer instead of a sensor, allowing for unexpected door closure. This could be particularly challenging for those who need more time to get through the door. The OIG recommends facility leaders improve doorway safety at the main entrance.

In clinical areas inspected, the OIG observed electrical cords cluttered floors and some were stretched to reach wall outlets; several equipment rooms were full, which made it difficult for staff to access items; and soiled utility rooms containing biohazardous materials lacked hand cleaning supplies. The OIG issued a recommendation related to inadequate hand cleaning supplies.

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. Facility staff had developed a policy for communication of test results; however, it did not include two VHA requirements: one for guidance on how to address life-changing test results for patients at high risk for suicide and another for a process for when a provider leaves abruptly.[7] Additionally, staff had not implemented processes to monitor test result notification to patients, or established service-level workflows to describe the communication process, as required. The OIG recommends facility leaders address these deficiencies.

The OIG also identified concerns with an automated process in the electronic health record system. The process automatically combines similar laboratory orders from different providers, which may result in one or more ordering providers not receiving notification of laboratory results. The OIG inspection team referred this issue to the OIG's hotline management team for further evaluation.

Further, the OIG noted four open recommendations from a May 2023 VHA Office of the Medical Inspector report.[8] The Chief of Quality and Patient Safety said staff had not updated the VHA Office of the Medical Inspector on the recommendations since September 2023. The OIG

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

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

[8] Department of Veterans Affairs, Office of the Medical Inspector, *Report to the Office of Accountability and Whistleblower Protection Case Number 23-20362*, May 2023. (This report is not publicly accessible.)

also found the facility had not sustained improvement for a closed recommendation related to annual mandatory provider training from a June 2022 OIG healthcare inspection report.[9]

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 affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[10]

At the time of the OIG site visit, the facility had 55 primary care teams. A primary care leader and staff reported experiencing burnout and fatigue due to large panel sizes and heavy workload.[11] The leader and staff added that when they open the two new clinics and add more teams, it should decrease the workload.

The OIG identified that enrollment had increased approximately 7 percent from fiscal years 2021 through 2023, which leaders attributed to nearby multiple military bases and the growing local veteran population. To increase access to care for new enrollees, the Assistant Chief of Primary Care Operations said leaders added weekend clinics, which decreased appointment wait times.

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. Staff were able to describe how they identify and engage veterans and meet their needs. The Health Care for Homeless Veterans Program Coordinator explained that staff identified veterans for program enrollment through various methods, such as contacts with shelters and the National Call Center for Homeless Veterans.[12]

The coordinator also discussed the challenges staff had with community outreach due to the facility's expansive service area, which also covers portions of North Carolina. Additionally, the

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[9] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, Report No. 21-03349-186, June 28, 2022.

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

[11] 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. "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).

[12] The National Call Center for Homeless Veterans helps veterans "who are homeless or at risk of homelessness" and is available "24 hours a day, seven days a week." "National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed September 10, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

coordinator explained they do not have contract shelter beds in North Carolina and therefore work with churches and community partners to shelter veterans in that state. The Homeless Programs Coordinator highlighted seven vacancies in social work positions that limit staff's ability to enroll veterans in the Housing and Urban Development–Veterans Affairs Supportive Housing program. The coordinator said prior facility leaders advertised the positions within their Veterans Integrated Service Network, which had been unsuccessful. The OIG recommends facility leaders increase hiring efforts for these vacant positions.

What the OIG Recommended

The OIG made six recommendations for improvement.

1. The Director evaluates accessible parking spaces at the circle of the main entrance and ensures access aisles have visible pavement markings and remain available for use.
2. Facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalks until completion.
3. Facility leaders improve doorway safety at the main entrance.
4. The Director ensures staff have adequate hand hygiene supplies in or near soiled utility rooms that contain biohazardous materials.
5. Facility leaders ensure the facility policy for communication of test results and service-level workflows comply with VHA requirements, and staff implement processes to monitor patient notification of test results.
6. Facility leaders increase hiring efforts for the vacant social work positions in the Housing and Urban Development–Veterans Affairs Supportive Housing program, and in the interim, provide staff to support program enrollment.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and Acting Executive Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes D and E, and the responses within the body of the report for the full text of the directors' comments). 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

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

FACILITY IN CONTEXT

VA Hampton Healthcare System
Hampton, Virginia
Level 1c-High Complexity Facility
Hampton County
Hospital Referral Region: Newport News

Description of Community

POPULATION

Female **371,000**	Male **350,081**
Veteran Female **16,879**	Veteran Male **72,373**

Homeless - State **6,529**
Homeless Veteran -State **392**

MEDIAN INCOME

$68,946

EDUCATION

92% Completed High School
67% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **146**

SUBSTANCE USE

29.0% Driving Deaths Involving Alcohol
18.3% Excessive Drinking
168 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+
3% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	279,573
Carpool	27,123
Work at Home	20,517
Walk to Work	7,771
Public Transportation	5,458
Other Means	5,042

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**36 Minutes, 31 Miles**
Specialty Care	**36 Minutes, 31 Miles**
Tertiary Care	**72 Minutes, 66 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 29,035

Veterans Receiving Teleheath (Facility)	49%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	12%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

25,584

380 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.00 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
17	28

Health of the Facility

UNIQUE PATIENTS

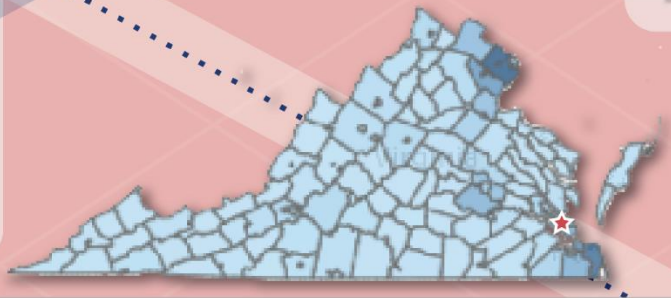
Unique Patients VA and Non-VA Care	70K
Unique Patients VA Care	66K
Unique Patients Non-VA Care	29K

COMMUNITY CARE COSTS

Unique Patient $23,726	Outpatient Visit $298
Line Item $913	Bed Day of Care $385

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.09%
Facility Total Loss Rate	14.48%
Facility Retire Rate	2.57%
Facility Quit Rate	10.83%
Facility Termination Rate	0.84%



★ VA MEDICAL CENTER

VETERAN POPULATION

0 — 75,438

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."*

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.

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

High Reliability Organization Framework

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

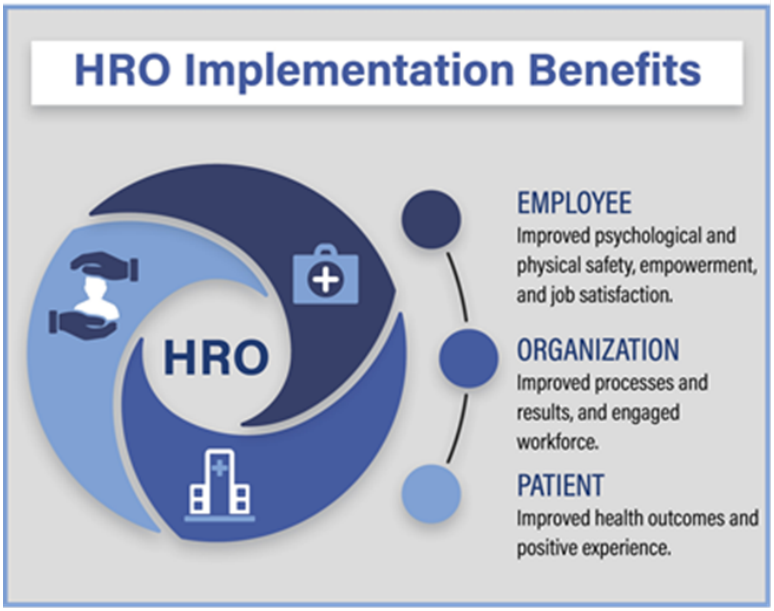


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

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.

[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 VA Hampton Healthcare System (facility) originally opened as a branch of the National Home for Disabled Volunteer Soldiers.[13] Facility staff reported that at the time of the inspection, the executive leaders consisted of the Acting Executive Director (Acting Director), assigned at the end of July 2024; Acting Chief of Staff, assigned the first week of August 2024; Associate Director Patient Care Services, appointed in March 2022; Associate Director, Clinical Business Operations, assigned in April 2024; Associate Director for Operations, assigned in June 2021; and Assistant Director, appointed in August 2023. In fiscal year (FY) 2023, the facility's budget was approximately $706 million. The facility had 387 operating beds, including 50 hospital, 40 inpatient mental health, 122 community living center, 47 spinal cord injury, and 116 domiciliary beds.[14] The facility provided healthcare services at locations in eastern Virginia and northeastern North Carolina.

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

[13] "Legislation for the creation of the National Asylum of Disabled Volunteer Soldiers was introduced to Congress on February 28, 1865," and was signed into law by President Lincoln in March 1865. The name was changed to the National Home for Disabled Volunteer Soldiers in 1873 "History of the National Home for Disabled Volunteer Soldiers," National Park Service, accessed October 31, 2024, https://www.nps.gov/articles/history.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/homeless/dchv.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.

leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

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.

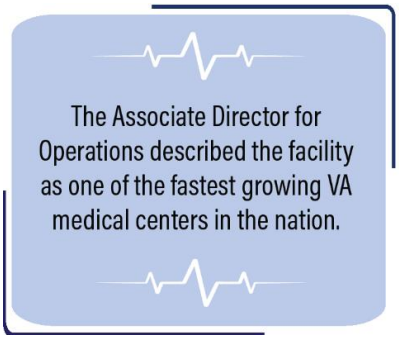


Figure 4. *Facility systems shock. Source: OIG interview.*

The executive leaders discussed recent system shocks as changes in the executive team, growth of the patient population, and new clinic infrastructure. At the time of the OIG site visit, the Acting Director was assigned from another VHA facility. The Veterans Integrated Service Network (VISN) Director had removed the prior Director pending an investigation, and the Chief of Staff and Chief of Surgery had stepped down, all within the previous month of the OIG visit.[20]

Additionally, the Acting Chief of Staff told the OIG that one of the facility's two anesthesiologists had resigned and left the facility the week of the inspection.[21] To address this staffing issue, the leaders described restructuring the surgery service, which had previously included the anesthesia staff; creating a new anesthesia service with five to six additional anesthesiologists; and hiring a chief of anesthesia, who will report to the Chief of Staff. Further,

[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.

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

[21] An anesthesiologist as a physician "who has special training in giving drugs or other agents to prevent or relieve pain during surgery of other procedures." "Anesthesiologist," National Institutes of Health, National Cancer Institute, accessed February 13, 2025, https://www.cancer.gov/publications/terms/anesthesiologist.

an acting chief of anesthesia would join the facility in the coming weeks; until then, they limited services by closing the endoscopy area and performing urgent endoscopy procedures in the operating room.[22]

The Associate Director for Operations discussed increased veteran enrollment, due in part to the PACT Act, and the facility's proximity to bases for multiple military branches. The associate director explained that large numbers of veterans enrolled every month, including approximately 1,000 in July 2024. To help serve the veterans in the area, the leader stated they would open two new clinics in the Chesapeake and Norfolk areas, described below. The facility is located on a peninsula, and according to the associate director, approximately 60 percent of the veterans came from the south and take tunnels or bridges to get to the facility or other clinics. The additional clinics would provide health care in the south side of the service area for the first time in the facility's history.

The Associate Director for Operations described the Battlefield Outpatient Clinic, planned to open in February or March 2025, which will be about 200,000 square feet. It will initially have 20 new primary care teams, which will increase to 28, and will offer laboratory and radiology services, multiple specialty care practices, and other services. The approximately 17,000 square foot Western Branch Clinic, opening in April or May 2025, will have primary care and mental health clinics.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[23] 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.[24] 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."[25] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[26]

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[22] In endoscopy procedures, healthcare providers use a scope to examine organs or areas inside the body. "Endoscopy," Cleveland Clinic, accessed October 18, 2024, https://my.clevelandclinic.org/diagnostics/endoscopy.

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

[24] 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*.

[25] 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.

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

The executive leaders described methods they used to improve communication with employees, focusing on town halls, huddles (short meetings between leaders and staff to share problems and identify solutions), and leadership rounding (visits with staff in work areas throughout the organization). The Acting Director identified an opportunity to train and empower service leaders to make decisions at their level rather than defer to executive leaders, such as determining when staff can work from home.[27] The Acting Chief of Staff said the new anesthesia service, described above, is an example of leaders' efforts to improve transparency and communication, and the change will make the reporting and responsibility structure for anesthesia staff more defined and improve leaders' oversight of the department.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[28] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[29] 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 OIG noted the facility's All Employee Survey score for the best places to work measure was much lower than VHA averages from FYs 2021 through 2023; although it improved from FYs 2022 to 2023, it remained lower than in FY 2021. The All Employee Survey scores for psychological safety were also lower than VHA averages, but they remained relatively unchanged from FYs 2021 through 2023. These results indicate that employees had concerns regarding psychological safety and whether the facility was a best place to work. Executive leaders described efforts to improve the employee experience, especially during the leadership changes. For example, leaders said they worked on ways to empower employee decision-making and reorganize services and reporting structures, but acknowledged there were still opportunities to improve the survey scores.

[27] The site visit pre-dated 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.

[28] "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.

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

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[30] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[31] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Responses to an OIG questionnaire indicated a patient advocate felt there were specific mechanisms for veterans to provide direct feedback to executive leaders, but they were not always responsive to veterans' concerns. The Chief of Patient Experience identified the three most common complaints as delays with provider communication and scheduling and rescheduling appointments, and billing from community care.[32]

The lead patient advocate explained that each service had an advocate who may not have time to adequately resolve complaints due to other duties. In addition, the lead patient advocate said service leaders often did not respond to complaints in a timely manner, and executive leaders did not adequately intervene when needed. The Acting Director, who had been in place approximately three weeks at the time of the OIG's visit, reported receiving daily reports of veterans' complaints and setting an expectation of accountability for designated staff and leaders to adequately address the complaints timely.

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

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

[32] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed November 21, 2024, https://www.va.gov/communitycare.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[33] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 5. *Facility photo. Source: "VA Hampton Health Care Locations," Department of Veterans Affairs, accessed July 25, 2024, https://www.va.gov/hampton-health-care/locations/.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[34] 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.[35]

[33] VHA Directive 1608(1).

[34] 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.

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

Transit and Parking

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

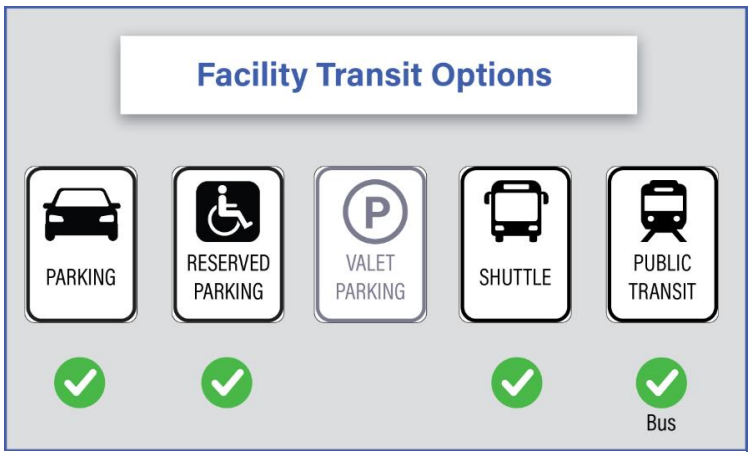

Figure 6. *Transit options at the facility.*
Source: OIG analysis of documents, observations, and interviews.

Patient advocate reports revealed trends in parking and transit concerns, and the OIG observed the problems during the site visit. The facility had multiple parking lots, but lot signage was either absent or difficult to see. In addition, parking was not clearly identified for patient versus staff use, and there were no signs directing patients to parking areas close to specific services, such as mental health or primary care clinics. The OIG noted parking lots with emergency call boxes, but the boxes were marked with signs indicating they were out of service. Leaders told the OIG that, after several unsuccessful attempts to fix them, another contract was underway for their repair; therefore, the OIG did not issue a recommendation. The OIG requests the Director consider improving the parking signs to increase visibility and provide better directions for patients.

The OIG noted the facility did not provide valet parking, and its shuttle service lacked a regular route, scheduled stops, and designated pick-up locations. One shuttle driver explained they received instructions to respond to calls for pick-ups or drop-offs, but the OIG did not see any phones for patients to use or any signs with a phone number to call the shuttle. The Associate Director for Operations said a workgroup authored a report with suggestions to improve and address the various parking concerns. The OIG requests the Director consider enhancing transit options for patients, such as creating a shuttle schedule and posting signage for shuttle stops and phone numbers to request the shuttle.

Additionally, the OIG observed the facility had parking spaces accessible for those with disabilities located around part of a drop-off circle at the main entrance. The Architectural Barriers Act requires accessible passenger loading zones, including access aisles (a designated area adjacent to accessible parking spaces for people exiting vehicles using wheelchairs or other mobility devices) that are next to the vehicle parking space and marked to discourage parking in them.[36] The OIG observed several vehicles parked in the access aisles, which could indicate poor enforcement of parking requirements. The OIG also found the pavement markings for the access

[36] Access Board, *Architectural Barriers Act (ABA) Standards*.

aisles were faded (see appendix C, figure C.1). In interviews, facility leaders said they were not aware of this issue and would evaluate it. The OIG recommends the Director evaluates accessible parking spaces at the circle of the main entrance and ensures access aisles have visible pavement markings and remain available for use.

The OIG also observed potential safety issues with some of the crosswalks, such as faded markings; missing detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel); inadequate street lighting; and missing crosswalk signs or a warning system (flashing lights or audible warnings) at both sides of several crosswalks, as required in the VA's *Site Design Manual* (see appendix C, figures C.2 and C.3).[37] The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalks until completion.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[38]

The OIG observed the facility's main entrance revolving door was out of service during the inspection week. Two additional swinging doors had push-button access for entry, but they appeared to be on a timer instead of a sensor, allowing the doors to close unexpectedly and cause challenges for those in need of more time to pass through the doorway. The OIG recommends facility leaders improve doorway safety at the facility's main entrance.

The main entrance lobby had a staffed information desk, adequate seating for those waiting for clinic appointments, a coffee shop, and seating at tables. However, in the mornings of the inspection week, the chairs were tilted and leaning on tables, which veterans could perceive as being unsafe or unavailable for use. The OIG noted staff left the chairs leaning on the tables after they cleaned the space.

At the Emergency Department entrance, which is used as the main entrance after normal business hours, the OIG observed dim lighting outside, which could limit visibility and pose a safety risk for veterans walking from the parking lot during night hours. Further, the OIG did not see any street-facing signs that identified the exterior entrance to the Emergency Department. The OIG requests facility leaders evaluate and consider improving lighting and signage outside the Emergency Department entrance to improve visibility and safety.

[37] Department of Veterans Affairs, Office of Construction and Facilities Management, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

[38] 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.[39]

The OIG observed a sign of clinic locations that did not include the Emergency Department, which could make it challenging for veterans to locate. Since other interior signs in the main lobby are adequate, and there are staff in the area to direct veterans if needed, the OIG did not make a recommendation.

Additionally, because of increased COVID-19 cases in the local area, the facility had reinstituted a mask-wearing requirement for anyone entering clinical areas. However, the OIG found signs with inconsistent messaging. For example, one sign said a mask must be always worn, but other signs indicated only when experiencing respiratory symptoms. The OIG also observed people walking around without masks, and the absence of readily available masks in some clinical areas, so veterans had to request them. The OIG informed leaders of the issue and they reported reinstituting this requirement the week before the inspection and attempting to resolve discrepancies; therefore, the OIG did not make a recommendation.

Finally, the OIG was able to gain access to multiple areas of the facility through unsecured doors identified as "authorized personnel only," which could create a security risk. The OIG requests that facility leaders evaluate and restrict access to secure areas to ensure safety for veterans, visitors, and staff.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[40]

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

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

[40] 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.

Staff at the main lobby information desk were able to describe how they would use language services and other support to assist hearing-impaired individuals, such as assistive listening systems. The OIG found tactile symbols (braille) on many signs.

However, the OIG observed several televisions in the lobby's central seating areas with the volume on, but none with closed captioning. The OIG requests facility leaders to consider using television closed captioning to improve experiences for hearing-impaired veterans.

The OIG also observed an electronic queue management system with large text in the laboratory and pharmacy areas, but it lacked a read-a-loud option to aid visually impaired veterans. The OIG noted the system was a positive feature for veterans to use but discussed an opportunity for leaders to evaluate whether the device could read the instructions aloud.

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.[41]

During an interview, the OIG found the toxic exposure screening staff to be knowledgeable and they explained the process for completing screenings. The OIG learned there were four staff who supported the navigator role, with one individual responsible for the program. All four navigators had other primary responsibilities, and this function was a collateral (additional) duty.

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

The OIG reviewed patient advocate reports and identified a trend in complaints about clinics remaining closed until almost the time of the first scheduled appointment for the day. On multiple days, the OIG observed the opening of two outpatient clinics (dental and dermatology). The OIG noted that doors to clinics' waiting rooms, which included the only available seating

[41] 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.

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

near the clinics, were not open until 7:30 a.m., despite veterans' scheduled appointment times of 8:00 a.m.

The OIG also observed a veteran with a mobility aid standing in the hall and being directed by a sign to wait in another area (Historical Hall) that was accessible only with stairs. The OIG watched as staff who entered the dental clinic did not greet or acknowledge veterans who were waiting. Additionally, one veteran mentioned receiving a cell phone message to go to the clinic but, upon arrival, found the clinic doors were locked. The OIG discussed these observations with the executive leaders, and one leader reported being aware of the sign at the dental clinic but believing it had been removed. The OIG requests the Director evaluate clinic opening procedures and consider alternatives to veterans waiting in the hallway or being directed to a seating area that is not accessible to all veterans.

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 multiple clinical areas and identified general themes related to the lack of a safe and functional environment.[43] The OIG observed several equipment rooms that were so full that it was difficult for staff to access items needed for patient care; one room had the full oxygen tanks in racks against a back wall. In addition, electrical cords for charging equipment cluttered the floors, some stretched to reach wall outlets or were plugged into extension cords lying on the floor, which could create tripping or fire hazards or damage to the equipment. The OIG requests facility leaders consider evaluating and addressing excessive storage in equipment rooms and electrical cord use.

The OIG also observed soiled utility rooms containing biohazardous materials lacked consistent availability of supplies to clean hands, such as hand soap, paper towels, and hand sanitizer, which increases the risk of contamination and spread of infection. The OIG recommends the Director ensures staff have adequate hand hygiene supplies in or near soiled utility rooms that contain biohazardous materials.

[43] The Joint Commission expects hospital staff to establish and "maintain(s) a safe, functional environment." The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, August 1, 2024.

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.[44] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The Acting Chief of Staff reported staff developed a facility policy, approved in November 2023, to comply with VHA's July 11, 2023, directive requiring facilities to develop a policy and service-level workflows (document describing processes for staff communicating test results to patients) within 6 to 12 months.[46] However, the OIG found that staff were still drafting the workflows at the time of the OIG site visit. The OIG also noted the policy did not include required elements, such as guidance on how to address life-changing test results for patients at high risk for suicide and a process for when a provider leaves abruptly.[47]

The Acting Chief of Staff, who had been in the role approximately two weeks at the time of the OIG visit, conceded the facility had not met the directive's time frame requirement for developing service-level workflows. The Acting Chief of Staff also acknowledged the policy's missing elements and reported a plan to revise it.

In addition, VHA requires that facility policies include processes to monitor the test result patient notification process.[48] The OIG noted the facility policy said the Medical Records Committee

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

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

[46] VHA Directive 1088(1).

[47] VHA Directive 1088(1).

[48] VHA Directive 1088(1).

would monitor the communication of test results to providers and patients.[49] However, the Acting Chief of Staff told the OIG the committee did not have current monitoring processes, but leaders planned to develop and implement them. The Performance Improvement Coordinator reported monitoring communication of test results through an external peer review program but acknowledged sample sizes were small, which made it difficult to draw meaningful conclusions.[50] The OIG recommends facility leaders ensure the facility policy for communication of test results and service-level workflows comply with VHA requirements, and staff implement processes to monitor patient notification of test results.

The OIG identified a risk related to delayed or inaccurate communication of test results, which can lead to missed identification of serious conditions.[51] During interviews, the Chief of Pathology and Laboratory Medicine described an automated process intended to reduce duplicate laboratory orders in which the system combines similar orders from different providers. The chief reported that when the system combines the orders, it does not notify one or more of the ordering providers of the results. The Chief of Pathology and Laboratory Medicine reported previously elevating the issue to the VHA national program office but it remained unresolved. The OIG referred this concern to the OIG's hotline management team for further review.

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

The OIG published hotline healthcare inspection reports about the facility in September 2023 and July 2024.[53] At the time of the OIG inspection, four of the seven recommendations from the

[49] Hampton VA Medical Center, "Communication of Test Results" (policy MCP 11-13), November 21, 2023. (This policy is not publicly accessible.)

[50] The external peer review program is a system process that supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. "External Peer Review Program (EPRP)," VHA Office of Informatics and Analytics, March 15, 2022, accessed April 11, 2024, https://department.va.gov/EPRP.pdf. (This website is not publicly accessible.)

[51] Murphy, Singh, and Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective."

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

[53] VA OIG, *Delay in Diagnosis and Treatment for a Patient with a New Lung Mass at the Hampton VA Medical Center in Virginia*, Report No. 22-02800-225, September 29, 2023; VA OIG, *Mismanaged Surgical Privileging Actions and Deficient Surgical Service Quality Management Processes at the Hampton VA Medical Center in Virginia*, Report No. 23-00995-211, July 23, 2024.

2023 report remained open. All facility action plans for the 2024 report's recommendations were in progress and not yet due for an update to the OIG.

Additionally, the OIG noted four open recommendations from a May 2023 VHA Office of the Medical Inspector report.[54] The Chief of Quality and Patient Safety explained that facility staff had not updated the VHA Office of the Medical Inspector about improvement actions since September 2023 due, in part, to them being busy managing their work and several oversight agencies' site visits. The chief said one recommendation was related to hiring an oncologist.[55] The chief added that leaders continue efforts to fill the position but have been unsuccessful, despite offering incentives like relocation assistance and student loan repayment.

The OIG also reviewed closed recommendations from another OIG healthcare inspection report related to test result communication, published in June 2022.[56] In response to one recommendation, the Director required staff to assign mandatory annual training to providers. However, staff did not provide evidence of annual training and therefore had not sustained improvement. The OIG requests facility leaders evaluate and consider improving processes to ensure staff actively track and sustain actions taken to address oversight report recommendations.

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.[57] 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.[58] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Facility leaders and staff explained their continuous learning process includes daily meetings with executive leaders, service-level leaders, and quality management staff to discuss issues and actions to resolve them, and share lessons learned. Leaders further stated they disseminate the information to frontline staff through smaller meetings, weekly town halls, and emails. A patient

[54] Department of Veterans Affairs, Office of the Medical Inspector, *Report to the Office of Accountability and Whistleblower Protection Case Number 23-20362*, May 2023. (This report is not publicly accessible.)

[55] An oncologist is a physician "who has special training in diagnosing and treating cancer." "Oncologist," National Institutes of Health, National Cancer Institute, accessed February 13, 2025, https://www.cancer.gov/oncologist.

[56] VA OIG, *Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia*, Report No. 21-03349-186, June 28, 2022.

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

[58] VHA Directive 1050.01(1).

safety manager reported also informing staff about issues and process improvements during monthly patient safety forums.

The Chief of Quality and Patient Safety said staff review oversight reports during committee meetings to identify trends and similar findings across reports that may warrant additional evaluation. To identify patient safety trends that were not associated with oversight reports, a patient safety manager described routinely reviewing the patient safety event reporting system and creating workgroups to address the issues as needed.

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

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[60] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[61] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG visit, the facility had the following vacancies across 55 primary care teams: one provider, two registered nurses, two licensed practical nurses, and two medical support assistants. Leaders stated they were actively working to fill the primary care team vacancies.

The Chief Nurse of Primary and Specialty Care explained that one challenge in primary care is not having enough space in their current clinics, which limits the number of patients who can be seen and results in longer appointment wait times. The Assistant Chief of Primary Care Operations reported adding weekend clinics once per month to increase access to care for new patients. The OIG identified that wait times for the fourth quarter of FY 2023 through the second

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

[60] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

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

quarter of FY 2024 had decreased from 42 to 30 days. The leader explained that staff volunteer to work overtime shifts to cover the weekend clinics.

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.[62] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[63]

The Assistant Chief of Primary Care Operations stated that large panel sizes were generally a concern for leaders and primary care staff. The assistant chief said that facility leaders had set primary care team panel capacity at 110 percent of VHA's target in early FY 2024.[64] However, during interviews, a leader and primary care staff said the increased panel sizes and heavy workload caused burnout and fatigue, although they expressed optimism that when they open the two new clinics and add more teams, it would help. Therefore, the OIG did not make a recommendation.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[65] 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 Chief Nurse of Primary and Specialty Care said leaders trained primary care team members on their roles and responsibilities at the beginning of FY 2024 to improve efficiency. The leader added that, at the time of the OIG visit, most teams had received this instruction.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that from FY 2021 through FY 2023, veteran enrollment increased approximately 7 percent. The Chief Nurse of Primary and Specialty Care attributed the increase partly to the facility's proximity to multiple military bases and the growing local veteran population.

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[62] "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).

[63] VHA Directive 1406(1).

[64] Modeled panel capacity is "the maximum number of patients a PACT [primary aligned care team] is expected to care for," which is currently set at 1,200. "Panel capacity for general PACTs will vary from facility to facility depending on patient characteristics and level of system support." VHA Directive 1406(1).

[65] VHA Handbook 1101.10(2).

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[66]

HCHV staff and the Homeless Primary Care Team used a mobile medical unit to serve veterans' healthcare needs in the community. The mobile unit traveled to different sites and provided private space for veterans to meet with medical providers and outreach staff.

Figure 8. *Best practice for veteran engagement. Source: OIG interview and document analysis.*

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).[67] 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."[68]

For FYs 2021 through 2023, the program had a VHA national program office waiver for the HCHV5 target because the facility did not have enough unsheltered veterans to qualify for the performance measure.[69] Starting in FY 2024, VHA no longer issued waivers for the measure, and the program had met the target from the first through the third quarter of FY 2024.[70]

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

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

[68] 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.

[69] During FY 2016, VHA enacted a waiver for exempt medical centers from the HCHV5 performance measure if there were not enough unsheltered veterans to meet the target. VHA Homeless Programs, *HCHV5: Engagement of Unsheltered Veterans – FY23 Exempted Sites*.

[70] The HCHV5 target for FY 2024 was 100 percent or above. VHA Homeless Program Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

The HCHV Program Coordinator said staff identified veterans for enrollment through contacts with shelters, day centers, community partners, and the National Call Center for Homeless Veterans, as well as self-referrals.[71] However, the coordinator explained staff had challenges with community outreach due to the facility's expansive service area, which covers portions of two states (Virginia and North Carolina) and includes seven cities separated by tunnels and bridges. The coordinator added the facility does not have contract shelter beds in North Carolina; therefore, staff work with churches and community partners to support veterans who do not want to travel to Virginia for shelter.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[72]

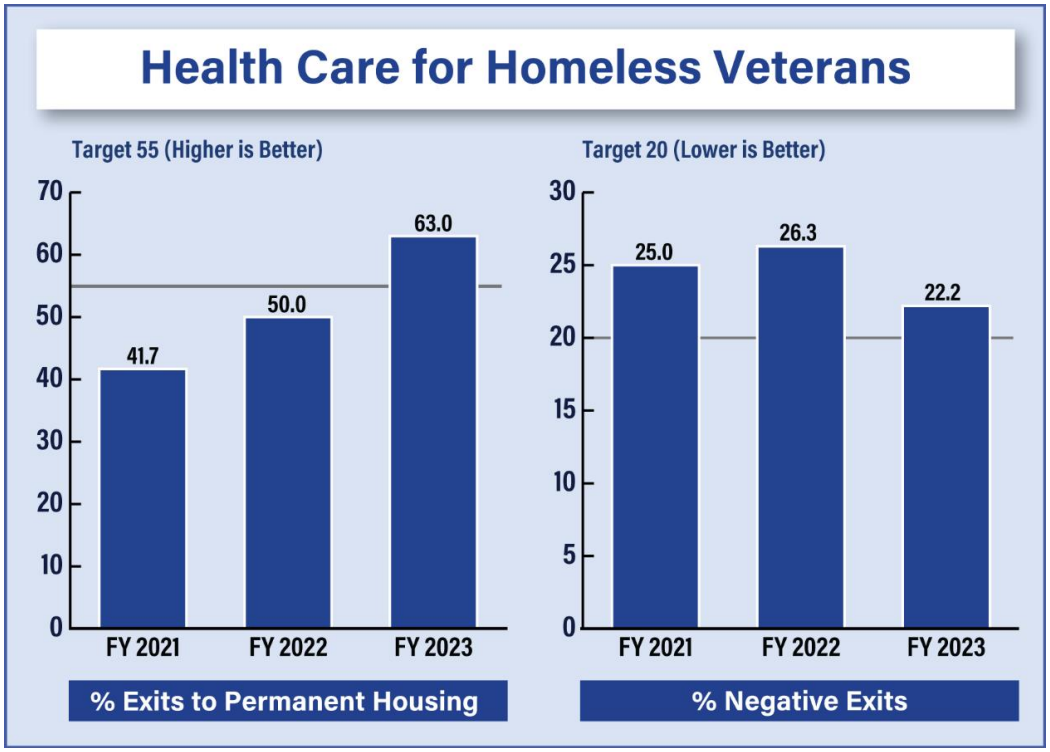

Figure 9. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

[71] The National Call Center for Homeless Veterans helps veterans "who are homeless or at risk of homelessness" and is available "24 hours a day, seven days a week." "National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed September 10, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

[72] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

The OIG found the program fell short of the HCHV1 target for FYs 2021 and 2022 but met it for FY 2023. The Homeless Programs Coordinator stated it was difficult to meet the targets in FYs 2021 and 2022 because of the COVID-19 pandemic. The coordinator explained that during that time, program enrollment was low, one shelter had fewer contract beds because of social distancing protocols, and the program was not fully staffed.

The OIG also found the program did not meet the HCHV2 target for FYs 2021 through 2023. Because of the small number of contract beds, the coordinator stated one or two veterans leaving a shelter program could unfavorably affect the measure.[73]

To meet veterans' healthcare needs, the Homeless Programs Coordinator said staff were co-located with the Homeless Primary Care Team. The HCHV Program Coordinator explained that staff collaborated with the Homeless Primary Care Team to refer veterans to the team, help assign them to a healthcare provider, and schedule an appointment.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[74] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[75]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[76] The facility's program did not meet the performance measure target for FY 2023. The Homeless Programs Coordinator reported the performance measure was new in FY 2023, and the program did not meet the target because staff did not consistently document their performance in the national reporting database. However, the coordinator said that documentation improved in FY 2024, after program leaders reviewed the national performance reporting requirements with staff.

A staff member told the OIG they identify and enroll veterans through referrals from courts, jails, prisons, and community agencies They also educate people in the community and at prisons about the program. The HCHV Program Coordinator identified staff turnover within the

[73] For example, in the second quarter of FY 2023, one shelter had four contract beds, and when two veterans left with a negative exit, the program received a 50 percent score for the quarter, and the target was 20 percent or below.

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

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

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

correctional facilities as a barrier to program referrals. The coordinator explained that points of contact in jails or prisons may change without their knowledge; however, staff are addressing this obstacle with their consistent communication efforts.

Meeting Veteran Needs

A program staff member said they serve veterans incarcerated in Virginia and North Carolina prisons, helping them with community re-entry upon release, and providing case management services. A staff member discussed housing and employment challenges for veterans with convictions, such as registered sex offenders who are ineligible for public housing, and said a community partner helps these veterans find jobs and a place to live. Additionally, the HCHV Program Coordinator explained they can refer veterans to the Legal Aid Society of Eastern Virginia through a VA grant to obtain help with legal matters.[77]

A program staff member also described successes. The staff member reported working with a homeless veteran who had struggled with substance use and financial management. The staff member worked with the public defender to help the veteran get substance use treatment and assisted the veteran with money management skills. At the time of the OIG site visit, the staff member said the veteran had stable housing and was in the process of buying a vehicle.

> The HCHV Program Coordinator, who oversees the Veterans Justice Program, and a program staff member explained that the Virginia Department of Veterans Services helps incarcerated veterans apply for federal and state benefits, and staff collaborate with the Virginia Department of Veterans Services and Veterans Benefit Administration to help veterans with housing, employment, and benefits after release.

Figure 10. *Meeting veterans' needs. Source: OIG interview.*

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."[78] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by

[77] The Legal Aid Society of Eastern Virginia "is a non-profit law firm that provides representation in civil matters to the low-income residents." "About Us," Legal Aid Society of Eastern Virginia, accessed October 30, 2024, https://www.laseva.org/node/44/about-us.

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

individualized services, including healthcare and employment assistance, necessary to maintain housing.[79]

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).[80] The program did not meet the target for FY 2021 through FY 2023.

The Homeless Programs Coordinator said the pandemic created barriers to meeting the target in FYs 2021 and 2022. The Housing and Urban Development–Veterans Affairs Supportive Housing Supervisor/Program Coordinator explained that because the public housing authority offices were closed, veterans had difficulty obtaining and submitting housing application documents. Both coordinators added that challenges to meeting the target since FY 2023 included increased rental costs, low housing availability, and program social work vacancies.

The Homeless Programs Coordinator explained that staff had challenges doing community outreach in the facility's expansive service area because drive times to some areas could be as long as four hours with traffic. The coordinator also discussed having seven social work position vacancies in the past year, adding that filling the positions would provide more staff to conduct outreach and enroll veterans into the program. The coordinator said the facility had advertised the positions within their VISN, without success.[81] To broaden the pool of candidates, staff had asked prior facility leaders to open the positions to the general public, but they had not approved the request.

The OIG recognizes that at the time of the site visit, the Acting Director and Acting Chief of Staff had been in place for less than a month, and the coordinator reported they had not made the request to these leaders. The OIG recommends facility leaders increase hiring efforts for the vacant social work positions in the Housing and Urban Development–Veterans Affairs Supportive Housing program, and in the interim, provide staff to support program enrollment.

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

[80] 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*.

[81] By law, these program positions are funded with earmarked dollars to prioritize ending and preventing homelessness among veterans. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Department of Housing and Urban Development–Veterans Affairs Supportive Housing Staff Funding for the September 2023 Voucher Allocation (VIEWS 11394907)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-22), June 20, 2024.

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).[82] The OIG found the program did not meet the target for FYs 2021 and 2022 but did for FY 2023.

The Homeless Programs Coordinator and Housing and Urban Development–Veterans Affairs Supportive Housing Supervisor/Program Coordinator stated the program had only one of three employment specialist positions filled for FYs 2021 and 2022, and during that time, staff did not consistently document their performance in the national data reporting system. However, since FY 2023, the program had all three employment specialists on board, and they consistently entered data into the reporting system.

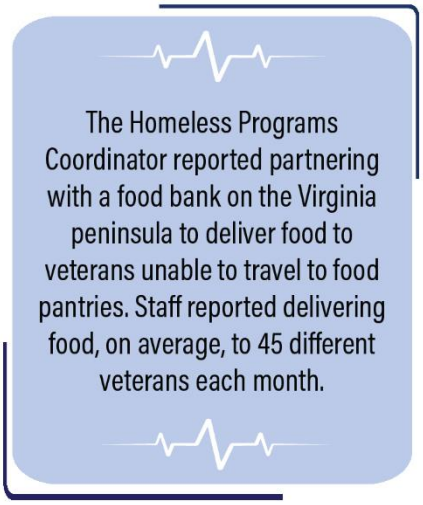

Figure 11. *Example of outreach and veteran engagement.*
Source: OIG interview.

The Homeless Programs Coordinator shared a success story involving a veteran who had a history of evictions that was living with their family in a hotel room. Program staff worked with the veteran to find a landlord who would accept their rental voucher and referred them to a veteran service officer who helped them obtain VA benefits. At the time of OIG site visit, the coordinator reported the family was flourishing in their housing unit.

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.

[82] 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 Response

Finding: At the main entrance's drop-off circle, the OIG observed several vehicles parked in the access aisles (designated areas adjacent to the parking space for people using wheelchairs or other mobility devices to enter or exit the vehicle) for accessible parking spaces. Also, the pavement markings for those access aisles were faded.

Recommendation 1

The OIG recommends the Director evaluates accessible parking spaces at the circle of the main entrance and ensures access aisles have visible pavement markings and remain available for use.

__X__ Concur

____ Nonconcur

Target date for completion: September 30, 2025

Director Comments

The Chief, Police Services completed a review of the accessible parking spaces at the circle of the main entrance and the exterior cameras that monitor that area. As of March 5, 2025, pavement markings have been painted. The parking area exterior cameras have been situated to allow police dispatch to continuously monitor the accessible parking spaces near the main entrance. The Police Dispatchers have been instructed to be aware of parked cars in the accessible parking spaces and to notify a Police Officer to respond. For sustainment, police have increased vehicle and foot patrols in the area to ensure access aisles are available for use and the Chief, Police Services will perform spot checks to ensure access aisles are accessible. Compliance will be reported monthly to the Environment of Care Committee by the Chief, Police Services until 90% compliance is achieved for six consecutive months.

Finding: Facility crosswalks had faded markings, missing detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel), inadequate street lighting, and missing crosswalk signs or a warning system (flashing lights or audible warnings) at both sides of several crosswalks.

Recommendation 2

The OIG recommends facility leaders improve crosswalk visibility and monitor pedestrian safety at the crosswalks until completion.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

After the OIG- HFI site visit in August 2024, the Chief, Facilities Management Services (FMS) conducted a review of the campus looking at crosswalks, warning surfaces, lighting, and crosswalk signs. As of March 5, 2025, all crosswalks have been painted throughout the facility. After reviewing high patient flow areas, seven (7) missing detectable warning surfaces were noted. A vendor was located for a surface applied product that allows installation without demolishing existing concrete. The process from ordering, receiving, and installing the new detectable warning surface in these high patient flow areas is expected to be completed by May 15, 2025. The lighting around the Emergency Department (ED) was noted as needing improvement. Three (3) additional lights were added around the ED providing exceptional surface lighting. In addition, the facility has retrofitted approximately 30 street light fixtures replacing metal halide lamps with LED lamps. This has increased the overall lighting level significantly. As a long-term measure, the facility has submitted a nonrecurring maintenance project to replace streetlights throughout the facility. The Acting Chief, Environmental Management Services (EMS) is collaborating with the Interior Design team to determine the number of crosswalk signs that are needed for the facility. Currently, the Hampton VAMC has a contract for exterior signage. In the interim, Police Services and the Safety Officer will monitor pedestrian safety at the crosswalks until the crosswalk signs are installed. The process for ordering, receiving, and installing the crosswalk signs is expected to be completed by 10/31/2025. This action will be monitored and tracked by the Acting Chief, EMS and reported to the Environment of Care Committee until completion.

Finding: The revolving door at the main entrance was out of service. Two additional swinging doors, which had push-button access for entry, appeared to be on a timer instead of a sensor, allowing for unexpected door closure that could be particularly challenging for those in need of more time to pass through the doorway.

Recommendation 3

The OIG recommends facility leaders improve doorway safety at the main entrance.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

After the OIG- HFI site visit in August 2024, the Chief, Facilities Management Services performed an assessment of the doorway safety at the main entrance. The revolving door in front of building 110B was re-activated and has been functional since September 3, 2024. The Electric Shop Supervisor assessed the swinging doors and observed Veterans and visitors using the

revolving/swing doors and there were no instances of a safety risk. The industry standard for the length of time an automated door is to remain open is ten (10) seconds. The swinging doors were reviewed and meet this basic criterion. A quote has been obtained for a motion sensor for the swinging doors. The process for ordering, receiving, and installing the motion sensor is expected to be completed by August 31, 2025. The Chief, FMS will perform monthly observations to ensure the revolving door is functioning and the swing doors are remaining open for ten (10) seconds. This action will be monitored and tracked by the Chief, FMS and reported to the Environment of Care Committee until completion.

Finding: Soiled utility rooms containing biohazardous materials lacked consistent availability of supplies to clean hands, such as hand soap, paper towels, and hand sanitizer.

Recommendation 4

The OIG recommends the Director ensures staff have adequate hand hygiene supplies in or near soiled utility rooms that contain biohazardous materials.

__X__ Concur

____ Nonconcur

Target date for completion: September 30, 2025

Director Comments

The Acting Chief, Environmental Management Services (EMS) assessed all of the sixteen soiled utility closets at the Hampton VAMC. The Acting Chief, EMS collaborated with the Interior Design team to determine the best placement of items for access to hand hygiene supplies in or near the soiled utility closets. Hand sanitizers, hand soap dispensers and paper towel dispensers are being installed in or near all soiled utility closets, with an expected completed date of March 28, 2025. EMS supervisors are rounding and huddling daily to validate hand hygiene products are available for all staff. The Acting Chief, EMS will perform weekly spot checks to ensure staff has hand hygiene supplies in or near soiled utility rooms. Compliance will be reported monthly to the Environment of Care Committee by the Acting Chief, EMS until 90% compliance is achieved for six consecutive months. Numerator: number of soiled utility closets with accessible hand hygiene products; Denominator: number of soiled utility closets.

Finding: Facility staff were still drafting service-level workflows, the policy for communication of test results to providers and patients lacked two required elements, staff had not implemented processes for monitoring and reporting test result notification to a facility committee.

Recommendation 5

The OIG recommends facility leaders ensure the facility policy for communication of test results and service-level workflows comply with VHA requirements, and staff implement processes to monitor patient notification of test results.

__X__ Concur

____ Nonconcur

Target date for completion: November 30, 2025

Director Comments

The Acting Chief of Staff has reviewed MCP 11-13, Communication of Test Results and VHA Directive 1088, Communicating Test Results to Providers and Patients. MCP 11-13 is in the process of being updated to include all required elements and service level workflows per VHA guidance. All providers will be trained on the revised local policy by the end of April 2025. The office of Quality and Patient Safety will perform a random review of 50 outpatient test results from 50 unique patients monthly beginning May 2025. Compliance will be monitored and reported monthly as a standing agenda item at the Medical Executive Council (MEC). Monitoring will continue until 90% compliance is met for six (6) consecutive months.

Finding: Attempts to fill seven social work vacancies in the Housing and Urban Development–Veterans Affairs Supportive Housing program had been unsuccessful.

Recommendation 6

The OIG recommends facility leaders increase hiring efforts for the vacant social work positions in the Housing and Urban Development–Veterans Affairs Supportive Housing program, and in the interim, provide staff to support program enrollment.

__X__ Concur

____ Nonconcur

Target date for completion: April 30, 2025

Director Comments

All seven (7) Housing and Urban Development- Veterans Affairs Supportive Housing (HUD-VASH) positions were approved for recruitment. Interviews were conducted and all seven (7) job offers were extended to potential candidates. Of the seven (7) offers, only one (1) declined. An alternate candidate was chosen to fill the seventh position. The six (6) candidates that have accepted the job offers are in different phases of the onboarding process. One (1) candidate has completed the onboarding process with an expected start date on March 10, 2025. Three (3)

candidates have a tentative start date for March 24, 2025, and two (2) candidates have a tentative start date for April 21, 2025. In the interim, the Program Manager and the Program Supervisor are assisting with program coverage until all candidates are on station and trained. The Acting Chief, Social Work will track and monitor the onboarding of these positions and report to the Medical Executive Council until complete.

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 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 August 19 through 21, 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 sent questionnaires to multiple VSO representatives and received responses from five.

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

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

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

Appendix C: Additional Facility Photos

Figure C.1. *Photo of accessible parking spaces in the main entrance circle drive. The middle car is parked on top of an accessible space's access aisle (a designated area adjacent to the parking space for people using wheelchairs or other mobility devices to enter or exit the vehicle).*
Source: Photo taken by OIG inspector.

Figure C.2. *Photo of an example of faded markings at one of the facility's crosswalks.*
Source: Photo taken by an OIG inspector.

Figure C.3. *Photo of main (left) and Emergency Department (right) entrances with example of a crosswalk with missing detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel).*
Source: Photo taken by an OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 10, 2025

From: Interim VA Mid-Atlantic Health Care Network Director (15N6)

Subj: Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia

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

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

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the Hampton VA Health Care System in Virginia.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Hampton VA Medical Center Leadership. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

(Original signed by:)

Mary Parker
VISN 6 Deputy Chief Medical Officer
For
Jonathan S. Benoit, MSHSA
Interim VA Mid-Atlantic Health Care Network Director, VISN 6

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: March 6, 2025

From: Acting Executive Director, VA Hampton Healthcare System (590)

Subj: Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia.
2. I have reviewed the draft report and concur with the recommendations. The findings outlined in the OIG report reflect a thorough evaluation.
3. If you have any questions regarding the information provided, please contact the Chief, Quality & Patient Safety.

(Original signed by:)

Walt Dannenberg, FACHE

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