US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Clarksburg Healthcare System in West Virginia

Healthcare Facility Inspection	24-03206-21	December 17, 2025

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

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Clarksburg Healthcare System (facility), from October 22 through 24, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders described homicides committed by a facility employee years prior that resulted in new leaders at the facility as a system shock.[2] Leaders said they tried to build trust, improve communication between employees and leaders, and develop a culture where employees felt safe reporting concerns. Leaders reported believing they accomplished this by providing trauma training for employees, implementing a relationship-building program, and communicating through storytelling. Leaders also explained they engaged directly with employees during town hall meetings and distributed a weekly newsletter to enhance communication.

[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] In 2020, the former employee pleaded guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder. VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

Leaders then discussed what they believed to be another system shock: temperature and humidity problems in the sterile processing and surgical services that resulted in a loss of medical supplies worth about $150,000. Leaders said the temperature and humidity issue did not lead to any patient safety issues; however, some patients' procedures did not start at the scheduled time. Leaders shared that they collaborated with facility subject matter experts and Veterans Integrated Service Network leaders to develop and implement standardized processes to identify, communicate, and track temperature and humidity events.[3]

To make sure veterans have good experiences, executive leaders said they meet with local veterans service organizations and patient advocates to discuss veterans' concerns, and patient advocates follow up with the appropriate service leaders to ensure employees address the issues.[4] Veterans can also share feedback directly with leaders through town hall meetings and focus groups. A patient advocate reported that 95 percent of veterans were satisfied with how leaders resolved their concerns.

Environment of Care

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

The OIG determined the facility had ample parking. The parking garage was well lit and had security cameras. However, the OIG found the passenger loading zone did not have a canopy to shelter patients from inclement weather. The facility had undergone a recent renovation, but leaders did not replace the previous canopy.

During the physical inspection, the OIG found concerns with general cleanliness. For example, staff stored clean and dirty equipment together in the Emergency Department ambulance bay. The OIG also noted torn waiting room furniture, which may prevent disinfection. Additionally, the main entrance and ambulance bay areas had dust, spider webs, dead insects, and insect traps containing pests. Finally, staff stored corrugated cardboard backboards in the ambulance bay

[3] Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed June 5, 2024, https://www.va.gov/HEALTH/visns.asp.

[4] Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf. Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

where they acknowledged known pest control issues.[5] The OIG issued recommendations to address these concerns. In response, the Director reported that a contracted exterminator sprayed the affected areas, and staff ensured clean and dirty equipment was stored separately, replaced torn furnishings, and will audit areas for environmental concerns. In addition, leaders stated that staff replaced the cardboard backboards with plastic backboards in the ambulance bay, and the OIG closed the associated recommendation (see OIG Recommendations and VA Responses).

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility's test result communication policy did not fully align with VHA guidance because it did not include the process to communicate urgent, noncritical test results between diagnostic providers and providers who order tests.[6] The OIG made a related recommendation. In response, the Director reported that staff are in the process of updating the local facility policy to comply with VHA requirements (see OIG Recommendations and VA Responses).

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected primary care delivery structure and new patient appointment wait times.[7]

The OIG found 16 vacancies among medical support staff. Primary care leaders said the vacancies began in December 2023, after Veterans Integrated Service Network leaders instructed executive leaders to reduce the number of employees due to funding constraints.

In addition, the OIG reviewed the number of patients assigned to a primary care team and found they did not generally exceed VHA's expected capacity of 1,200 patients.[8] Staff told the OIG they had begun seeing new patients on Saturdays, which opened more appointment slots during

[5] Corrugated cardboard is "susceptible to moisture, water, vermin and bacteria during warehouse or storeroom storage, as well as transportation environments." "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed July 23, 2025, https://www.jointcommission.org/en-usstandards-interpretation/standards-faqs.

[6] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024; Louis A. Johnson VA Medical Center MCP [medical center policy] 11-001, *Communication of Test Results to Providers and Veterans*, September 2024.

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

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

the week and kept wait times low for all patients. Primary care providers and staff believed the number of assigned patients was manageable.

Primary care staff also reported initiating several projects to improve patients' access to care. One project began after primary care leaders found that clinic staff had canceled patient appointments for various reasons, including training that was scheduled during clinic hours. The leaders said their improved oversight of the appointment process reduced the cancellation rate from 21.9 percent in fiscal year (FY) 2022 to 12.1 percent in FY 2024.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The facility's Health Care for Homeless Veterans program did not meet the target for engaging with unsheltered veterans in FY 2024, although its performance progressively improved throughout the year. The OIG noted program staff had close working relationships with community partners that enabled them to quickly help meet veterans' needs. Program staff said that after increased collaboration, these partners are allowing veterans second chances rather than immediately discharging them from housing for rule violations.

The Housing and Urban Development–Veterans Affairs Supportive Housing program met the target for securing housing for veterans issued vouchers. Staff informed the OIG they have strong relationships with landlords and reported instances when veterans received a voucher and moved into housing the same day. Staff also discussed the program's annual community event to unite service providers in a collaborative effort to meet the needs of homeless veterans. However, the facility did not meet VHA's target for the percentage of employed veterans in FY 2024. Program staff explained they worked with many veterans and not all were eligible for employment, making it difficult to meet the metric.

The facility's Veterans Justice Program missed the enrollment target in FY 2024, which staff attributed to the small local veteran population. Staff said they identified veterans for enrollment through monthly reports from jails and during monthly prison visits. Once enrolled, staff connect incarcerated veterans with resources, facilitate access to substance use treatment and housing, work with veterans after their release to prevent relapse, and support reintegration into the community.

What the OIG Recommended

The OIG made three recommendations.

1. Executive leaders ensure staff store clean and dirty equipment separately, repair torn furnishings, and keep the environment clean.
2. Executive leaders ensure staff evaluate the cardboard backboards for pest concerns and reduce the risk of infection.
3. Executive leaders ensure the facility's policy for test result communication aligns with the VHA directive.

VA Comments and OIG Response

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

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

Abbreviations

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

FACILITY IN CONTEXT

VA Clarksburg Healthcare System
Clarksburg, West Virginia
Level 1c-High Complexity Facility
Harrison County
Hospital Referral Region: Morgantown

Description of Community

POPULATION

Female **422,022**	Male **424,539**
Veteran Female **5,309**	Veteran Male **56,065**

Homeless - State **1,375**
Homeless Veteran - State **122**

MEDIAN INCOME

$47,814

EDUCATION

87% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **224**

SUBSTANCE USE

30.9% Driving Deaths Involving Alcohol
15.9% Excessive Drinking
322 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
6% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	297,540
Carpool	31,399
Work at Home	21,107
Walk to Work	11,441
Other Means	4,647
Public Transportation	3,605

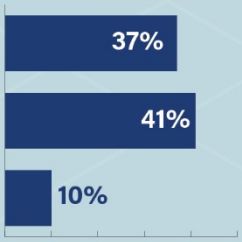
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**39 Minutes, 29.5 Miles**
Specialty Care	**63.5 Minutes, 54.5 Miles**
Tertiary Care	**131 Minutes, 126.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **7,048**



Health of the Veteran Population

130 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

5,668

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.85 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
25	42

Health of the Facility

UNIQUE PATIENTS

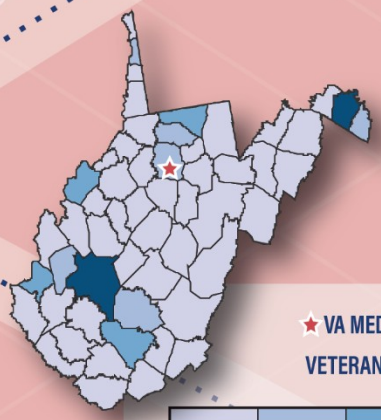
Unique Patients VA and Non-VA Care	22K
Unique Patients VA Care	21K
Unique Patients Non-VA Care	11K

COMMUNITY CARE COSTS

Unique Patient	$36,764
Outpatient Visit	$328
Line Item	$2,509
Bed Day of Care	$334

STAFF RETENTION

Onboard Employees Stay <1 Yr	17.26%
Facility Total Loss Rate	10.69%
Facility Retire Rate	2.37%
Facility Quit Rate	7.27%
Facility Termination Rate	0.96%



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

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Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

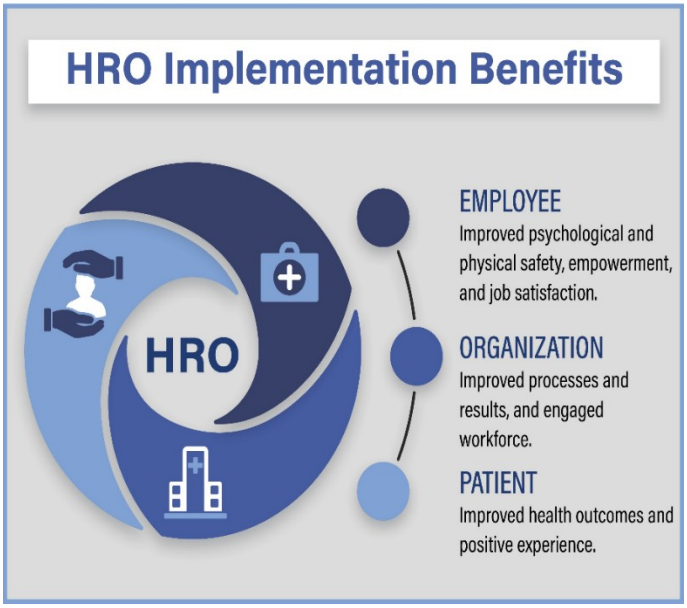

Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

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

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

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

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

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

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

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

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

PACT Act

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

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

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

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

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

Content Domains

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

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

The Louis A. Johnson VA Medical Center, part of the VA Clarksburg Healthcare System (facility) opened on December 7, 1950, and in 1989, additional clinical space expanded the facility. The facility serves a veteran population of approximately 70,000 in north central West Virginia and adjacent counties in Maryland, Ohio, and Pennsylvania. In fiscal year (FY) 2023, the facility's budget was approximately $352 million. It had 103 inpatient beds distributed across acute hospital care, residential treatment programs, and nursing home care.

The OIG inspected the facility from October 22 through 24, 2024. The facility had an executive team consisting of the Executive Director (Director); Associate Director; Chief of Staff; and Associate Director, Patient Care Services. The team's newest member, the Associate Director, Patient Care Services, was appointed in April 2022.

A 2018 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[13] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[14] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[15]

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

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

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

System Shocks

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

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In an interview, executive leaders discussed the homicide of several veterans by a facility employee several years before, which resulted in the assignment of new executive leaders.[18] The leaders reported believing the crimes of one person destroyed the facility's good reputation. They further explained that it took about a year before the current leaders were in place, and during this time, several interim employees covered the associate director, patient care services, and chief of staff positions.

Executive leaders said they prioritized building trust with employees to repair the psychological stress they had experienced and offered training on managing workplace trauma. Leaders also stated they successfully implemented VA Voices, a program that helps employees make connections between their personal values and their work.[19] The leaders reported a positive shift in the facility's culture and attributed it to increased communication and engagement efforts by all facility leaders.

Executive leaders identified a different system shock: a recent failure of the humidity and temperature controls in the sterile processing and surgical areas. Leaders reported staff had noticed fluctuating temperature and humidity levels in the areas, sometimes outside of the normal range. Staff also noticed an increased number of sterile processing packages that failed quality standards for use after being sterilized. Leaders explained that this resulted in staff discarding a significant number of medical supplies, at a cost of about $150,000. While this problem did not result in any patient safety issues, leaders said some patients experienced a delayed start for their scheduled procedures.

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

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

[18] In 2020, the former employee pled guilty to seven counts of second-degree murder and one count of assault with the intent to commit murder. VA OIG, *Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 20-03593-140, May 11, 2021.

[19] National Center for Organization Development, *Employee Engagement Newsletter, VA Voices—Building Care through Better Relationships*, October 2019.

Leaders acknowledged staff lacked a standardized process to report temperature and humidity issues to service and executive leaders. For example, staff frequently contacted leaders via phone or text to inform them of issues; however, if the leader was covering for a different position or out of the office, they could miss the information. Additionally, staff did not clearly communicate what needed to be fixed, or the progress they made toward resolving the issue, which made it difficult for leaders to make informed decisions.

Leaders said they collaborated with frontline staff, other subject matter experts, and Veterans Integrated Service Network (VISN) leaders to develop a standard operating procedure for managing supplies that could be affected by temperature and humidity problems.[20] To improve communication, leaders established a virtual channel as a single location to document all temperature and humidity concerns, actions, and resolutions. Leaders explained that staff corrected the problems and will monitor areas for any recurring issues.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[22] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[23]

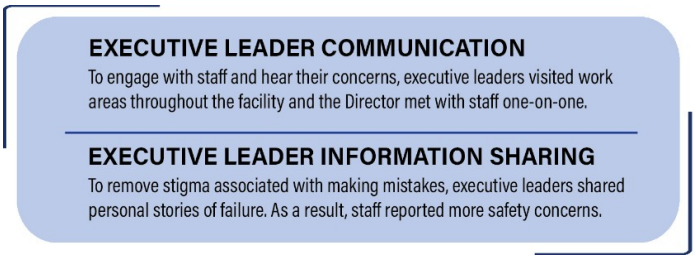

Figure 4. *Leader communication with staff.*
Source: OIG interview with executive leaders.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information. Survey scores about leader communication improved from FY 2021 through FY 2023 and OIG questionnaire respondents perceived leaders' communication to be clear, useful, and frequent. During OIG interviews, leaders reported they encouraged staff to participate in the All Employee Survey and

[20] Veterans Integrated Service Networks (VISNs) are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed June 5, 2024, https://www.va.gov/HEALTH/visns.asp.

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

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

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

implemented improvement actions based on survey results. Leaders said they increased their engagement with employees by holding town hall meetings and distributing a weekly facility newsletter, which they believed contributed to positive staff perceptions about communication.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[24] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[25] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

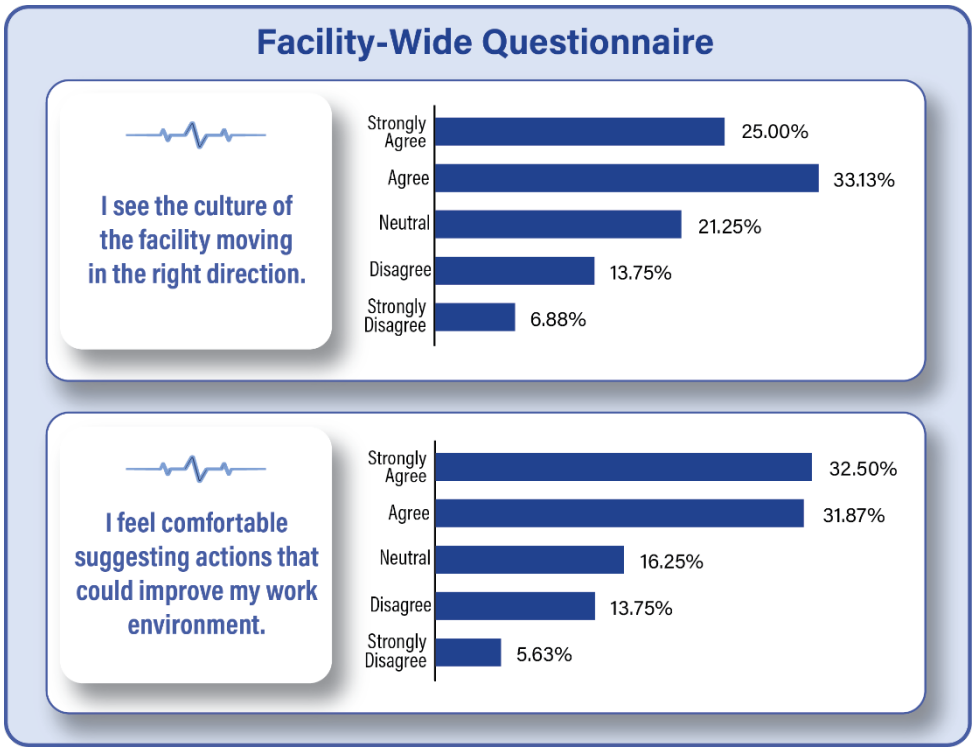

Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

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

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

Both survey scores and answers to the OIG questionnaire indicated employees generally feel comfortable reporting safety concerns and suggesting ways to improve their work environment. Executive leaders said they provided clear goals for employees, such as taking care of veterans first. They also hold a yearly Failure Fair event in which employees share safety stories and actions they took to improve the situations, and leaders celebrate their achievements.

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.[26] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[27] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

A patient advocate response to an OIG questionnaire indicated that veterans' top complaints involved receiving bills for care they received in the community, requests for a different provider, and contact center wait times.[28] When asked to describe actions taken to improve veterans' contact center concerns, leaders acknowledged that a technology issue caused veterans' calls to be dropped (disconnected).

Leaders said they are currently working with the information technology staff to resolve the issue. They also encouraged staff to share with veterans that they are working to resolve the issue and offer to assist as needed. The advocates explained that veterans have several ways to provide direct feedback to facility leaders, who are responsive to their concerns. For example, veterans can share their feedback at town hall meetings and in focus groups, as well as through the Veterans Experience Office, which focuses on ensuring veterans have good customer experiences with VA.

A patient advocate reported that 95 percent of veterans were satisfied with the resolution of their issue. Executive leaders said they discuss veterans' concerns daily with the patient advocates, who then follow up with the appropriate service leaders to resolve the issues. Leaders also stated they have a positive relationship with local VSOs, some of whose members also serve on the facility's Veterans Advisory Board.

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

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

[28] "Veterans may be eligible for care through a provider in their local community depending on their health care needs or circumstances, and if they meet specific eligibility criteria. In most cases, Veterans must receive approval from VA before receiving care from a community provider to avoid being billed for the care. VA staff members generally make all eligibility determinations for community care." VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[29] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 6. *Facility photo. Source: "Louis A. Johnson Veterans' Administration Medical Center," Department of Veterans Affairs, accessed November 15, 2024, https://www.va.gov/clarksburg-health-care/locations.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[30] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[31]

[29] VHA Directive 1608(1).

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

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

Transit and Parking

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

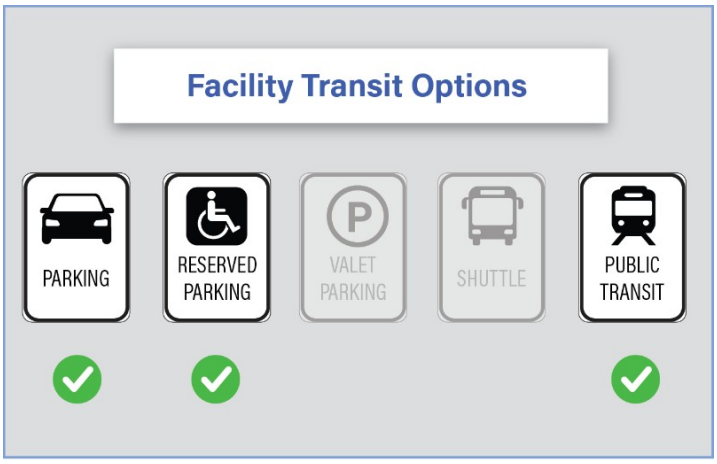

Figure 7. *Transit options for arriving at the facility. Source: OIG observations.*

The OIG used the address on the facility's website and a commercial phone application to arrive at the main entrance without difficulty. There was a nearby public bus stop with a bench. The OIG noted the parking garage and lots offered ample parking, including spaces accessible for those with disabilities. The parking garage was well lit, had security cameras, and used automatic sensor lights to illuminate the area when needed.

The OIG noted a passenger loading zone near the main entrance did not have a canopy to shelter veterans from the weather. Staff explained that a recent facility renovation did not include replacing the previous canopy and added it would require a new project proposal. Although the OIG made no recommendation, executive leaders should evaluate ways to protect veterans from inclement weather in passenger loading zones.

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.[32] The main entrance had power-assisted doors and was well lit and spacious. The OIG observed assistive devices such as wheelchairs and electric scooters near the entry door, along with a coffee bar, designated room for breast feeding, and seating for veterans to socialize.

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

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

whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[33]

The OIG observed printed color maps at the information desk and hall signs; however, no other wayfinding tools, such as a mobile application or kiosk, were available to help veterans navigate the facility. VA recommends various forms of wayfinding tools so individuals can use their preferred method.[34] The Comprehensive Environment of Care Coordinator explained that the facility had a kiosk, but leaders discontinued its use during the COVID-19 pandemic to reduce the risk of spreading the disease when different people touched it.

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The OIG confirmed the availability of braille and audio announcements in the elevators. Information desk staff said they communicate in writing and personally escort veterans with sensory impairments to their destinations, when needed. Staff reported that waiting room televisions had closed-captioning capability.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility

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

[34] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies;* Department of Veterans Affairs*, PG-18-10, Design Manual*.

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

based on VA's guidelines.[36] The facility had two navigators who reported having sufficient space and resources to screen veterans for toxic exposure. The OIG reviewed the facility's toxic exposure screening performance data and noted the average wait time for secondary screenings (completed when veterans report an exposure) was less than eight days.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[37]

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

Based on interviews and Environment of Care Committee meeting minutes and reports, the OIG determined staff tracked concerns they identified during monthly environment of care inspections and implemented corrective actions. The OIG did not identify any repeat environment of care findings.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy. The OIG inspected five units: the Medical Surgical Unit, Intensive Care Unit; Primary Care Clinic; Emergency Department, including the attached ambulance bay; and the Community Living Center. The OIG had concerns about the general cleanliness of the facility.

The OIG noticed clean and dirty equipment stored together in the Emergency Department ambulance bay; worn and torn furnishings in outpatient waiting room areas, which may prevent staff from effectively cleaning and disinfecting the surfaces; and dust in air ventilation units throughout a corridor and a room designated for breast feeding. VHA requires that staff store

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

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

clean and soiled items separately to prevent the transmission of infections, and facilities have a safe and clean environment.[38]

The nurse manager explained that, due to limited storage space in the units and the Emergency Department, staff placed clean items in the hall or ambulance bay to avoid obstructing the exits. The Comprehensive Environment of Care Chair stated the facility has experienced delays in furniture orders following the COVID-19 pandemic. The OIG recommended executive leaders ensure staff store clean and dirty equipment separately, repair torn furnishings, and keep the environment clean. In response, the Director explained staff replaced the torn furnishings, separated clean and dirty equipment, and will audit areas for environmental concerns (see OIG Recommendations and VA Responses).

The OIG also noticed the ambulance bay and main entrance had spider webs, dead insects, and insect traps containing pests. Comprehensive Environment of Care Committee staff explained the pest concerns are ongoing because pests get underneath the doors. Staff also said leaders have a contract with a pest control company to provide regular services, and staff are able to address issues as they find them. Further, the OIG observed disposable corrugated cardboard backboards stored in an open cabinet in the ambulance bay. According to The Joint Commission, corrugated boxes can harbor moisture, pests, and bacteria during storage.[39] Emergency Department staff explained that they switched from reusable to cardboard backboards because, in the past, ambulance service staff used the facility's reusable backboards to transport patients and did not return them, which lead to frequent equipment loss.

The OIG is concerned about the use of these backboards to transport patients from the ambulance bay into the Emergency Department where the potential exists to carry bacteria or pests into a clean exam room.[40] Therefore, the OIG recommended executive leaders ensure staff evaluate the cardboard backboards for pest concerns and reduce the risk of infection. In response, leaders provided evidence that staff replaced the cardboard backboards with plastic backboards, and the OIG closed the recommendation (see OIG Recommendations and VA Responses).

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

[39] "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed July 23, 2025, https://www.jointcommission.org/en-us/standards-interpretation/standards.

[40] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG found the facility's test result communication policy did not fully align with the VHA directive. Specifically, the policy did not define how diagnostic providers communicate urgent, noncritical test results to ordering providers.[43] However, leaders clarified this communication occurred through electronic view alerts (notifications in the electronic health record system) and added that ordering providers use clinical judgment to decide which urgent results require patient follow-up. The Chief of Staff reported that after seven days, the electronic health record system automatically notifies the ordering providers' service chiefs of unaddressed view alerts. The OIG recommended executive leaders ensure the facility's policy for test result communication aligns with the VHA directive. In response, the Director explained staff are in the process of updating the facility's policy to comply with the VHA directive (see OIG Recommendations and VA Responses).

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

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

[43] VHA Directive 1088(1); Louis A. Johnson VA Medical Center MCP [medical center policy] 11-001, *Communication of Test Results to Providers and Veterans*, September 2024.

Action Plan Implementation and Sustainability

Figure 9. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[44] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG noted recommendations from an April 2024 Joint Commission survey, and the OIG's comprehensive healthcare inspection were closed.[45] The Assistant Chief, Quality and Risk Management said the accreditation nurse updates executive leaders quarterly on the status of all open recommendations open longer than a year through the Executive Leadership Board.

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.[46] 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.[47] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

During an interview, quality management staff and executive leaders said they use a variety of methods to identify patient safety concerns and opportunities for improvement. For example, leaders explained they conduct monthly audits of how long diagnostic providers take to communicate critical test results to ordering providers, referred to as turn-around time. Though the diagnostic providers met their turn-around time goal, laboratory staff implemented a process improvement project in January 2024 to further reduce the time to allow ordering providers quicker access to critical tests results.

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

[45] VA OIG, *Comprehensive Healthcare Inspection of the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia*, Report No. 23-00108-149, April 23, 2024.

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

[47] VHA Directive 1050.01(1).

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[48] 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.[49] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[50] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Primary care leaders said the facility had 8 vacancies for medical support staff in September 2024, which increased to 16 in October 2024. They reported the vacancies began in December 2023, when VISN leaders instructed executive leaders to reduce the number of employees due to funding constraints. After several support staff positions became vacant, leaders identified scheduling errors, such as new patients scheduled in established patient appointment slots, leaving too little time for staff to complete the appointment. The Director subsequently submitted an emergency request to fill two vacant support staff positions, which the VISN approved.

Primary care leaders shared that support staff are difficult to recruit and retain because the positions are entry-level; as support staff gain skills and knowledge, they often seek higher-paying or remote positions. Leaders added they previously increased pay to retain support staff, which reduced vacancies. The Director explained they are exploring options to cover the workload, such as offering retention incentives to current support staff, using contractors, and sharing staff between VA facilities in the area.

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

[49] 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).

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

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.[51] The OIG examined the facility's primary care teams' actual and expected panel sizes, or the number of patients assigned to a care team, relative to VHA guidelines.[52]

VHA requires that primary care panels do not exceed the capacity of 1,200 patients.[53] The OIG reviewed panel size data for FY 2022 through the third quarter of FY 2024 and found that panels generally did not exceed the expected size; primary care staff described their panels as manageable. Additionally, the OIG reviewed patient wait time data from the first quarter of FY 2023 through the third quarter of FY 2024 and found appointment wait times averaged five to seven days for established patients and three to six days for new patients. Staff attributed the low wait times to initiatives such as referring established patients to pharmacists for appointments that do not require a provider, and seeing new patients during Saturday clinics to open more weekday appointment slots.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[54] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

In an interview, primary care staff shared that leaders support their requests for process improvements. For example, leaders implemented the Primary Care Advisory Committee in February 2023 to help staff plan, develop, and track process improvement projects, and team members have initiated several projects to improve patients' access to care. An ongoing project involves reducing facility-initiated appointment cancellations at the primary care clinic to avoid delayed care. Primary care leaders reviewed clinic data and identified reasons for the cancellations, such as staff training scheduled during clinic hours or appointment slots that remained available when providers were scheduled to be on leave. Through several actions, including increased oversight of cancellations and the use of VA Video Connect appointments, primary care staff and leaders decreased the clinic cancellation rate from 21.9 percent in FY 2022 to 12.1 percent in FY 2024.[55]

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

[52] VHA Directive 1406(2).

[53] VHA Directive 1406(2).

[54] VHA Handbook 1101.10(2).

[55] VA Video Connect is a videoconferencing application that allows veterans and to meet with VA providers through live video. "VA Video Connect," VA Mobile, accessed October 28, 2024, https://va.gov/va-video-connect.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that veteran enrollment remained stable and patient appointment wait times had not increased.

Leaders said staff had difficulty contacting veterans to conduct toxic exposure screenings. Leaders stated they held two PACT Act events in collaboration with other government agencies to reach veterans and complete their screenings. For example, during a September 2024 event, VA staff offered screenings and benefits claim support to about 400 veterans.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[56]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[57] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[58]

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

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

[58] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

The program did not meet the performance target in FY 2024.[59] HCHV staff told the OIG they identify veterans for homeless program enrollment through various sources, such as street outreach, shelters, and the facility's Residential Rehabilitation Treatment Program and inpatient medical units.[60] They emphasized their commitment to responding to veterans' needs and ensuring they receive a program intake assessment. As a result, the program's performance improved each quarter in FY 2024 and reached 88 percent in quarter four.[61] Additionally, staff said they help some veterans who are not in the program with household problems, such as a leaking roof, and the measure did not reflect this type of assistance.

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).[62] In FY 2024, the facility met the HCHV1 target but did not meet the HCHV2 target.[63] Program staff explained they had increased collaboration with community partners to improve the HCHV2 measure. For example, a local community partner no longer discharged veterans immediately for rule violations and instead offered them another opportunity to adhere to the rules. As a result of this flexibility, the program had zero discharges for rule violations in quarter four of FY 2024.

HCHV staff also discussed some challenges in covering a large, 22-county service area, particularly when veterans had limited transportation to get to the facility or shelters. Staff explained that pandemic-era rideshare options that helped veterans with transportation issues from rural locations are no longer available.

[59] VHA sets escalating targets for HCHV5 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 2024 Homeless Performance Measures*, October 1, 2023.

[60] Street outreach is "outreach to Veterans experiencing unsheltered, street homelessness taking place in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[61] The facility's HCHV5 performance for FY 2024 was 20 percent in quarter one, 40 percent in quarter two, and 60 percent in quarter three of FY 2024.

[62] 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*.

[63] In FY 2024, the facility's HCHV1 performance was 63 percent, and its HCHV2 performance was 26 percent.

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."[64] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[65]

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).[66] The program met the target in FY 2024.[67] Staff reported they identify veterans through various sources to assist with finding housing, such emergency departments and the VA Grant and Per Diem Program, as well as veteran self-referrals.[68] Staff told the OIG that anytime a veteran reaches out for support, the team makes sure to follow up as soon as possible.

Program staff stated they have strong relationships with landlords, which sometimes allowed veterans to find housing and move in the same day they received a voucher. In addition, when the local housing authority has scheduling constraints that delay immediate assistance, program staff said they place veterans in a temporary Grant and Per Diem Program dormitory to keep them safe until housing becomes available. Staff shared a range of additional resources available to ensure homeless veterans receive appropriate care based on their specific needs, such as VA medical foster homes.[69]

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

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

[66] 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*.

[67] The facility's FY 2024 HMLS3 performance was 90 percent.

[68] The VA Homeless Providers Grant and Per Diem Program "provides safe supportive housing and supportive services for homeless Veterans through grants with community-based programs." VHA Directive 1162.01, *VA Homeless Providers Grant and Per Diem Program*, November 17, 2020.

[69] "A MFH [medical foster home] is a private home in which a MFH caregiver provides care to a Veteran resident and the MFH caregiver lives in the MFH." VHA Directive 1141.02, *Medical Foster Home Program*, February 7, 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).[70] The facility did not meet the target in FY 2024.[71]

Program staff explained that few veterans were eligible for employment, and some were retired due to disability. Because of this, staff said even one or two employment status changes can significantly affect the overall performance measure.

Program staff told the OIG they meet monthly with Supportive Services for Veterans and Families to track veterans' housing status.[72] For resources the program is unable to provide, such as air mattresses for veterans who do not have a bed, staff rely on community partners. Staff also described the program's annual community homeless event, Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups), which brings together homeless service providers, advocates, veterans, and citizens to collaboratively meet the needs of homeless veterans.[73] They shared a success story from a community event in which staff helped an individual who had fallen from their wheelchair. After learning the individual was a veteran, staff helped with housing and a referral for a service-connected disability evaluation.

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]

[70] 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*.

[71] The facility's FY 2024 VASH3 performance was 40 percent.

[72] The Supportive Services for Veteran Families "program provides supportive services to very low-income Veteran families in or transitioning to permanent housing." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[73] VA Clarksburg Healthcare System, "CHALENG 2024" (flyer), August 22, 2024.

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

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

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 target in FY 2024.[77] Program staff told the OIG they believed the goal is difficult to meet because of the area's small justice-involved veteran population.

Program staff said they identify veterans for enrollment through referrals from legal professionals, monthly reports from jails, and monthly prison visits. Additionally, incarcerated veterans or their family members can contact program staff to seek enrollment.

Staff shared successful initiatives not reflected in the performance measure, such as the facility's no-cost driving under the influence course. Veterans who complete the training can get their driver's license reinstated while avoiding the financial burden of course fees.

Meeting Veteran Needs

To help meet veteran needs, program staff said they advocate for them to have improved access to treatment. Staff further explained that some veterans cannot leave their county, which limits their ability to attend the local VA rehabilitation program and may keep them from meeting court orders for treatment.

Staff told the OIG they also connect incarcerated veterans with resources for any housing needs and advocate for the veteran's release. Additionally, staff said they work with veterans after incarceration to decrease the likelihood of substance abuse relapse and to help them reintegrate into the community. Staff highlighted another Veterans Justice Program success story where they engaged with and supported a veteran with a history of drug use and criminal behavior. After receiving support through the VA homeless and rehabilitation treatment programs, the veteran was able to gain stable housing and graduate from college.

[76] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.
[77] The facility's FY 2024 VJP1 performance was 43 percent.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to cleanliness and test result communication. Leaders have started to implement corrective actions, and completed corrective actions for one recommendation, which the OIG closed (see OIG Recommendations and VA Responses). Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

OIG Recommendations and VA Responses

Recommendation 1

Executive leaders ensure staff store clean and dirty equipment separately, repair torn furnishings, and keep the environment clean.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2026

Director Comments

The facility's Environmental Management Service leadership collaborated with Quality and Risk Management to review the recommendations. Environmental Management Service staff remediated the dust and pest control concerns immediately. On October 23, 2024, the facility's contracted exterminator company sprayed the Emergency Department ambulance bay and front entrance for pests and continues to make bi-monthly appointments to the facility to inspect and replace the pest traps.

The storage of the clean and dirty equipment separately within the Emergency Department ambulance bay was corrected October 24, 2024. The facility also replaced the torn furnishings in the Emergency Department and Surgery waiting areas.

To aid in the timely identification and remediation of dust and pest control concerns, the Environmental Management Services and Quality Management department developed and implemented a Multidisciplinary Environment of Care Audit on October 14, 2025. Environmental Management Services and Patient Care Services staff will collaborate to complete one audit per month in each of the following areas: Emergency Department, Medical Surgical Unit, Intensive Care Unit, Community Living Center and Primary Care areas. The denominator will be the total number of concerns identified in the Multidisciplinary Environment of Care audits within the five patient care areas per month. The numerator will be the number of identified concerns remediated within one business day of identification per month. A minimum of 90 percent compliance will be achieved for six consecutive months. Quality Management will report data to the Quality and Patient Safety Committee, which is chaired by the Medical Center Director.

OIG Comments

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

Recommendation 2

Executive leaders ensure staff evaluate the cardboard backboards for pest concerns and reduce the risk of infection.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

To promote infection prevention strategies, the Executive Leadership Team ensured that the facility had durable plastic backboards available for use and discarded the cardboard backboards on October 24, 2024.

The Emergency Department Nurse Manager further enhanced these efforts by implementing additional plastic backboards from the facility's Emergency Management Service on October 28, 2024, which remain in use in the Emergency Department.

The signed attestation by the Associate Director, Patient Care Services and the Chief of Staff serve as verification of the process change. We request OIG consider closure of this recommendation based on evidence provided.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 3

Executive leaders ensure the facility's policy for test result communication aligns with the VHA directive.

_X_ Concur

____ Nonconcur

Target date for completion: February 27, 2026

Director Comments

The Louis A. Johnson VA Medical Center will develop a checklist outlining requirements within VHA Directive 1088 Communicating Test Results to Providers and Patients July 11, 2023 (amended September 20, 2024). The checklist will be utilized to review facility policy to ensure compliance with VHA Directive 1088. Local policy(s) will be updated based on review findings. This recommendation will be considered compliant upon completion of the checklist indicating

conformity with VHA Directive 1088. Findings will be reported to Quality and Patient Safety Council, which is chaired by the Medical Center Director.

OIG Comments

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

Appendix A: Methodology

Inspection Processes

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

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

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

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from October 22 through 24, 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, 2021, through September 30, 2023.

[2] The OIG received a response from three VSOs.

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 25, 2025

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

Subj: Healthcare Facility Inspection of the VA Clarksburg Healthcare System in West Virginia

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

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

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled – Healthcare Facility Inspection of the VA Clarksburg Healthcare System in West Virginia.
2. I have reviewed the attached comments and corrective actions provided by the Medical Center Director, Clarksburg, W.V., VA Medical Center. I concur with the request to close recommendation two. Recommendation one and three will remain open and in progress.
3. Should you require any additional information please contact the VISN 5 network office.

(Original signed by:)

Joseph M. Scotchlas, FACHE
Deputy Network Director, VA Capitol Health Care Network
for and in the absence of,
Robert M. Walton, FACHE
Network Director, VA Capitol Health Care Network

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 25, 2025

From: Director, VA Clarksburg Healthcare System (540)

Subj: Healthcare Facility Inspection of the VA Clarksburg Healthcare System in West Virginia

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

1. I have reviewed the report entitled “Healthcare Facility Inspection of the VA Clarksburg Healthcare System in West Virginia.” I concur with the recommendations and have submitted supporting documentation to request closure for recommendations two. I will ensure the actions to correct any remaining open findings are completed and sustained as described in the responses.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
3. If you have any questions, please contact the Chief of Quality or the VISN 5 Quality Management Analyst.

(Original signed by:)

Barbara Forsha, MSN, RN, CPHQ, CPPS, ET
Executive Director, Louis A Johnson VA Medical Center

OIG Contact and Staff Acknowledgments

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