US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

Healthcare Facility Inspection	24-00594-61	March 5, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Central Western Massachusetts Healthcare System (facility) from July 9 through 11, 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. Staff and leaders identified turnover in key leadership positions as a system shock. The executive leadership team included four acting leaders out of five positions, although several had worked in other roles at the facility prior to their current assignment.

Leaders also described recent VHA staffing reductions as a system shock and discussed how they communicated the changes to other leaders and frontline staff.[2] Leaders said they took advantage of the opportunity to improve efficiencies in the facility's committee reporting structure and encouraged staff to participate in the changes by sharing their input on which

[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] The purpose of the memo was "to provide high-level hiring, vacancy, and attrition guidance" to leaders without sacrificing exceptional veteran care due to the FY 2025 budget. Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors and VHACO Program Office Leadership, May 31, 2024.

committees are needed and how they function. Leaders also focused on creating a culture of trust and collaboration among the service leaders.

Regarding veterans, leaders said the patient advocate team addressed their complaints, which the most common were difficulty contacting their care team and navigating the telephone system.[3]

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.

A portion of the main lobby was under construction, but the remaining area was generally clean. The OIG found features to assist veterans with visual impairments in navigating the facility but noted closed captioning not being used on televisions in common areas to support those with hearing impairments. The OIG inspected several clinical and nonclinical areas and found them to be generally clean and maintained. Although the OIG found stained ceiling tiles in multiple locations, staff had already identified the problem as an improvement opportunity. The OIG also found expired supplies maintained outside appropriate storage locations in patient care areas. Because this could result in unintended use of expired supplies, the OIG made a recommendation.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found staff had processes for alerting providers about test results and monitoring data on patient notification of test results. At the time of the OIG site visit, facility leaders were developing local policies for communicating test results to providers and patients and were still within the time frame VHA had given to complete this task.[4]

[3] Patient advocates are facility 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/.

[4] VHA's July 2023 update to the directive allowed facilities 6 to 12 months to create a local policy and service-level workflows, which describe the team member roles in the communication process for communicating test results to providers and patients. VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

The OIG also closed a recommendation following the site visit for staff to complete disruptive behavior training from a September 2021 OIG report.[5] Additionally, facility staff highlighted their huddles (brief meetings) that included frontline staff and biweekly patient safety town halls as examples of strong continuous learning practices.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[6]

Staff and the Local Service Line Manager for Primary Care reported primary care panel size (the number of patients assigned to a care team) and workload to be generally adequate. The service line manager said sick call teams (a team of staff who are available to work when staff are out sick, or positions are vacant) and medical providers who are not assigned a full panel help cover vacant positions. Leaders and the service line manager said the staffing shortages and the PACT Act had little effect on appointment wait times or primary care delivery.

Primary care staff said service leaders were supportive and they had good communication with leaders. The Local Service Line Manager for Primary Care shared an example of a performance improvement project in which a nurse contacted veterans not recently seen by a provider to set up a new appointment. At the time of the OIG visit, 2,598 of the 5,441 veterans contacted had accepted an appointment.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. Homeless program staff receive referrals in various ways to enroll veterans in the programs and refer them for healthcare, housing, and financial services as needed. Staff highlighted a resource room where they store various items, such as coats, sleeping bags, and blankets, for homeless veterans to use.

Staff discussed limited transitional housing beds and emergency shelters for veterans in Worcester County, but they were working on a contract to secure additional space. Staff also discussed challenges in helping veterans obtain housing, which include housing voucher amounts

[5] VA OIG, *Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 21-00263-246, September 14, 2021.

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

below average rental costs in the area, and elderly veterans who need assistance in the home. Staff emphasized the 44 housing units on the facility's campus that are available for rent by elderly veterans with housing vouchers; and the approval to hire a nurse, nursing assistant, occupational therapist, and peer support specialist to assist those who need it. However, the program supervisor said staff were not recruiting for the nurse and nurse assistant due to VHA's staffing reduction guidelines.

What the OIG Recommended

The OIG made one recommendation.

1. Facility leaders assess storage locations outside of standard supply rooms and implement a process to ensure staff remove expired supplies.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Interim Executive Director agreed with the inspection finding and recommendation and provided an acceptable improvement plan (see appendixes C and D, and the response within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

Abbreviations

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

VA Central Western Massachusetts Healthcare System
Leeds, Massachusetts
Level 3-Low Complexity
Hampshire County
Hospital Referral Region: Springfield

FACILITY IN CONTEXT

Description of Community

POPULATION

Female 916,274	Male 870,050
Veteran Female 8,199	Veteran Male 86,962

Homeless - State **15,507**

Homeless Veteran -State **534**

MEDIAN INCOME

$65,493

EDUCATION

93% Completed High School

68% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **339**

SUBSTANCE USE

29.5% Driving Deaths Involving Alcohol

22.7% Excessive Drinking

799 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+

4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	675,374
Work at Home	68,047
Carpool	66,349
Walk to Work	32,643
Public Transportation	16,433
Other Means	14,423

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**16.5 Minutes, 9.5 Miles**
Specialty Care	**45.5 Minutes, 38 Miles**
Tertiary Care	**114 Minutes, 109 Miles**

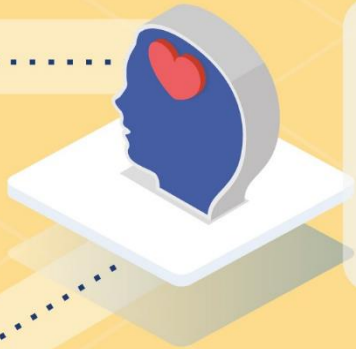
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 8,274

Veterans Receiving Teleheath (VHA)	41%
Veterans Receiving Telehealth (Facility)	33%
<65 without Health Insurance	5%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

8,374

94 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

N/A

30-DAY READMISSION RATE

N/A

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
10	19

Health of the Facility

UNIQUE PATIENTS

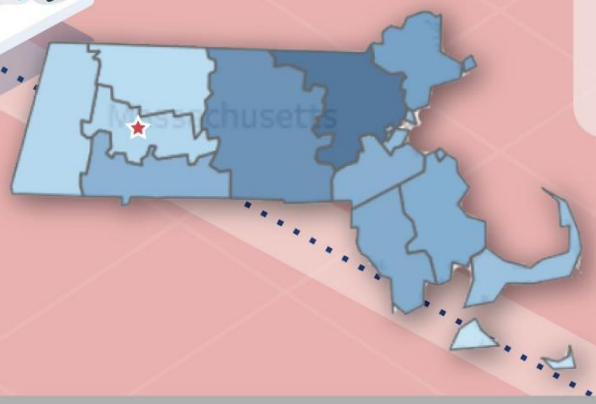
Unique Patients VA and Non-VA Care	29K
Unique Patients VA Care	27K
Unique Patients Non-VA Care	14K

COMMUNITY CARE COSTS

Unique Patient $40,272	Outpatient Visit $297
Line Item $3,901	Bed Day of Care $342

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.31%
Facility Total Loss Rate	14.63%
Facility Retire Rate	3.42%
Facility Quit Rate	9.50%
Facility Termination Rate	1.62%



★ VA MEDICAL CENTER

VETERAN POPULATION

592 — 56,111

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

Contents

Background and Vision

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

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

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

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about

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

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

High Reliability Organization Framework

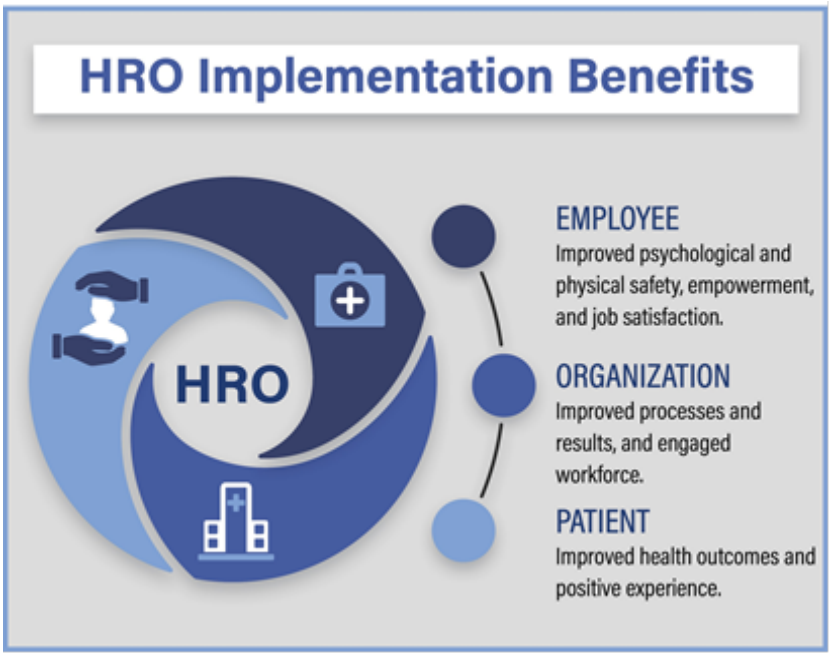


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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]

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

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

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

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

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

[6] "VHA 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.)

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

PACT Act

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

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

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

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

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

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

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

Content Domains

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

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

The VA Central Western Massachusetts Healthcare System (facility) opened in 1924.[13] At the time of the OIG inspection, the System Redesign Lead reported approximately 10,000 square feet of the primary care area was undergoing renovation. The facility's executive leaders consisted of the Acting Director, Acting Chief of Staff, and Acting Assistant Director, all assigned in March 2024; the lead said the Associate Director Patient Care Services/Nurse Executive was appointed in July 2022, and the Acting Associate Director in July 2023. The lead also stated that in fiscal year (FY) 2023 the facility's budget was approximately $382 million. The facility had 129 operating beds, which included 20 acute mental health, 30 community living center, and 79 domiciliary beds.[14]

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

[13] The VA Central Western Massachusetts Healthcare System includes the Edward P. Boland VA Medical Center in Leeds. "About the VA Central Western Massachusetts Healthcare System," Department of Veterans Affairs, accessed December 11, 2024, https://www.va.gov/central-western-massachusetts-health-care/about-us/.

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

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

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

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

System Shocks

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

Respondents to the OIG's facility-wide questionnaire identified turnover in key leadership positions as the primary system shock. The OIG found four of the five executive leadership team members were in acting positions. In an interview, the executive leaders acknowledged staff's concerns about leadership stability. The Acting Director reported being hired about two years previously as the Associate Director, then becoming Acting Director one year later, when the former Director was detailed (temporarily assigned) to another facility. The leader also said the Acting Chief of Staff was hired as Deputy Chief of Staff in October 2023 and assigned to the current position about a month later, when the prior Chief of Staff announced the planned departure. Despite the acting roles, executive leaders highlighted that several of them had worked at the facility in other positions, which helped minimize disruptions to daily operations.

The Acting Director identified another system shock as VHA's FY 2024 guidance related to budget and staffing reductions.[20] The Acting Director discussed how executive leaders communicated the changes to other leaders and frontline staff and used the opportunity to improve efficiencies in the governance (committee reporting) structure and streamline policies and processes.

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

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

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

[20] The purpose of the memo was "to provide high-level hiring, vacancy, and attrition guidance" to leaders without sacrificing exceptional veteran care due to the FY 2025 budget. Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors, and VHACO Program Office Leadership, May 31, 2024.

Leadership Communication

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

Most respondents to the OIG's questionnaire indicated that leaders' communication was generally clear. The Acting Director stated service leaders used huddles (brief meetings) to ensure communication flowed between leaders and staff. Executive leaders shared that they participated in meetings at least twice a month with service leaders and quarterly with frontline supervisors to ensure consistent communication and discussion. The leaders also said they attended various town hall meetings and patient safety forums.

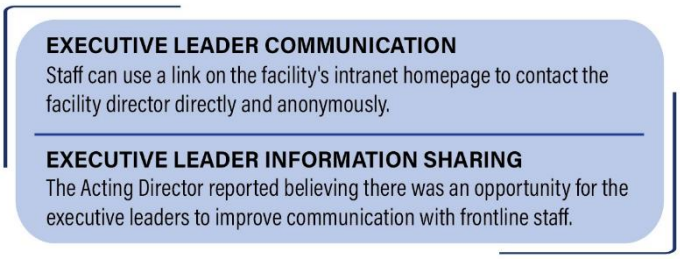


Figure 4. *Executive leader communication with staff. Source: OIG interview with facility leaders.*

The Acting Director reported believing executive leaders could improve their rounding (visits to staff in their work areas) with a more structured process in which staff are aware of the leader's scheduled visit and submit items to discuss in advance. The Acting Director reported having completed two of these rounding events with staff.

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

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

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

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

Employee Experience

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

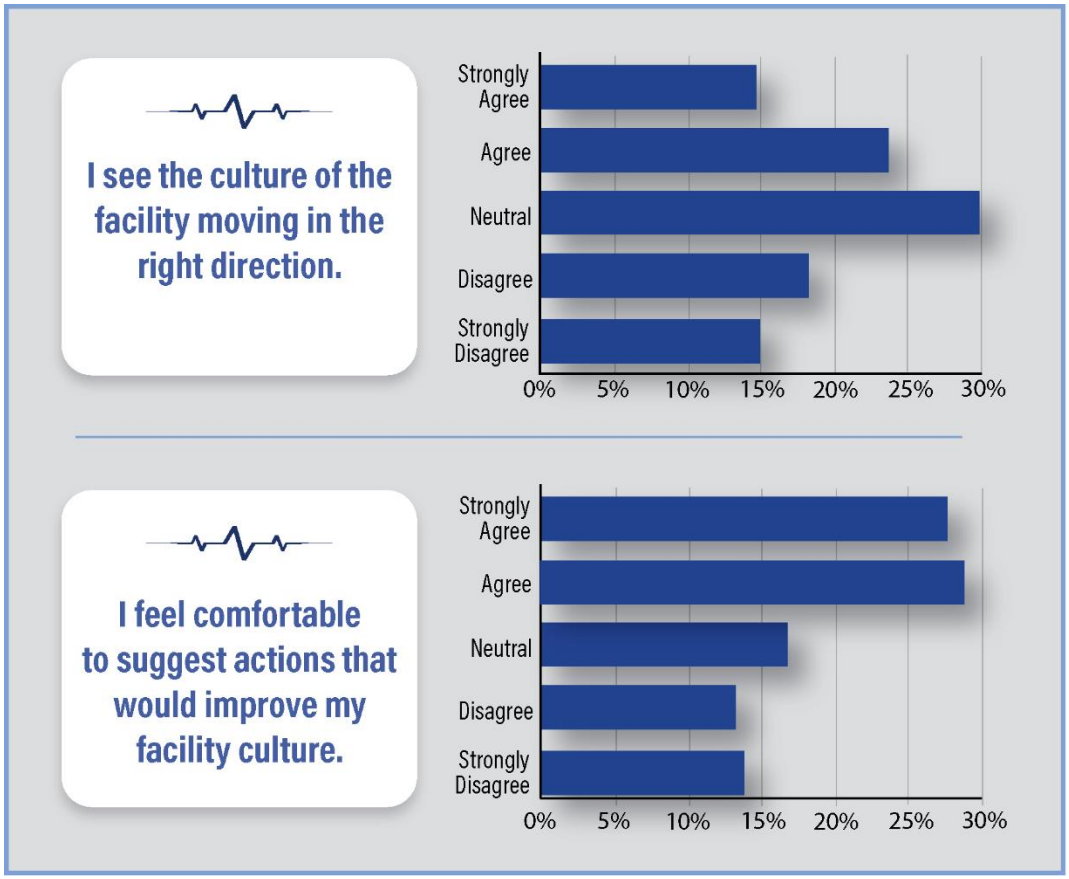


Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The questionnaire evaluated what motivated employees to continue working at the facility and what encouraged them to seek other employment. Respondents indicated that pay and benefits

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

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

and the VA mission were reasons to stay; while stress, burnout, and bad leadership were reasons to seek employment elsewhere. The OIG shared these results with the executive leadership team, and the Acting Director responded that the feedback revealed areas needing improvement.

Leaders pointed again to recent leadership turnover and the improvements they had made and planned to make. Regarding the committees, the Acting Director explained the executive leadership team encouraged employees to be part of the restructuring process by sharing their opinions, proposing solutions, and participating in decision-making on issues, such as which committees are needed and how they function. The Acting Director also stated that over the past year, executive leaders were creating a culture of trust and collaboration by empowering service leaders to make decisions rather than relying on executive leaders to make them; however, the leader acknowledged it was going to take time for the culture to change.

Veteran Experience

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

The OIG identified the most common themes from patient advocate and VSO responses as

- difficulty contacting the care team,
- difficulty navigating the telephone system, and
- increased wait time for appointments.

The Acting Associate Director reported believing the patient advocate team addressed veterans' complaints and was helpful and collaborated with staff. The Acting Director reported having a good relationship with local VSOs but identified one area for improvement as consistent attendance from VSO representatives at the monthly meetings with the Acting Director to address concerns and share general information. The Associate Director Patient Care Services/Nurse Executive gave an example of how VSO representatives supported operations during the COVID-19 pandemic by assisting veterans with transportation to the facility and providing space at locations in the community for staff to screen veterans and administer vaccinations.

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

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

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: Photo taken by OIG inspector.

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

Transit and Parking

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

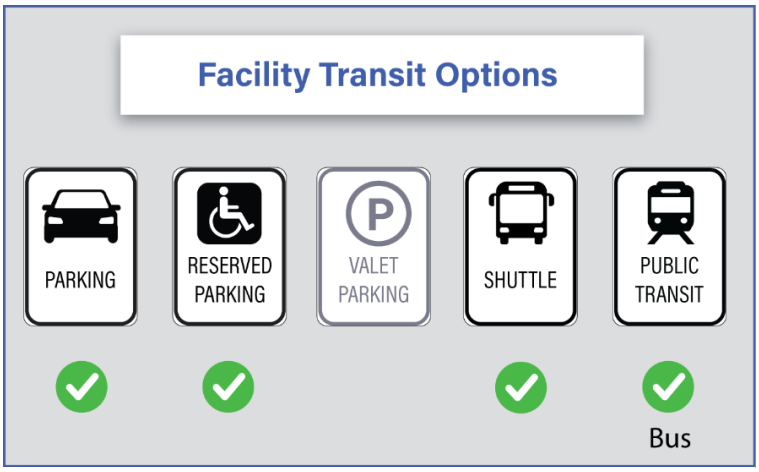


Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of document, observations, and interviews.

The OIG used a commercial navigation application to travel to the facility and found the directions easy to follow. A staff member located at a guard station in front of the main entrance was available to provide directions to veterans. The OIG noted veterans' parking spaces available near building entrances. The OIG also observed freestanding, color-coded directories at each side of the main patient parking lot.

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]

External signage directed veterans through covered walkways to the main entrance. At the main entrance, the OIG observed a passenger loading zone with a canopy, power-assisted doors with access ramps, and wheelchairs available just beyond the door. Even though a portion of the main lobby was undergoing construction, the remaining area was well lit and generally clean. Staff at the information desk, with additional support from volunteers, help with navigation. In addition, the OIG witnessed staff at the guard station and main entrance collaborating to bring wheelchairs outside for veterans when needed.

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, *VA Signage Design Guide*.

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

The OIG observed maps on the walls in multiple buildings and noted the main lobby's information desk staff provided printed maps on request. The OIG also used navigational cues and wall directories to navigate the facility, and leaders said a mobile navigation application was in development.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[34] During the inspection, the OIG found multiple features to assist veterans with visual impairments navigate the facility, including large-print maps and raised symbols (braille) on signs. Additionally, the information desk staff said they help people with visual impairments get to their destinations.

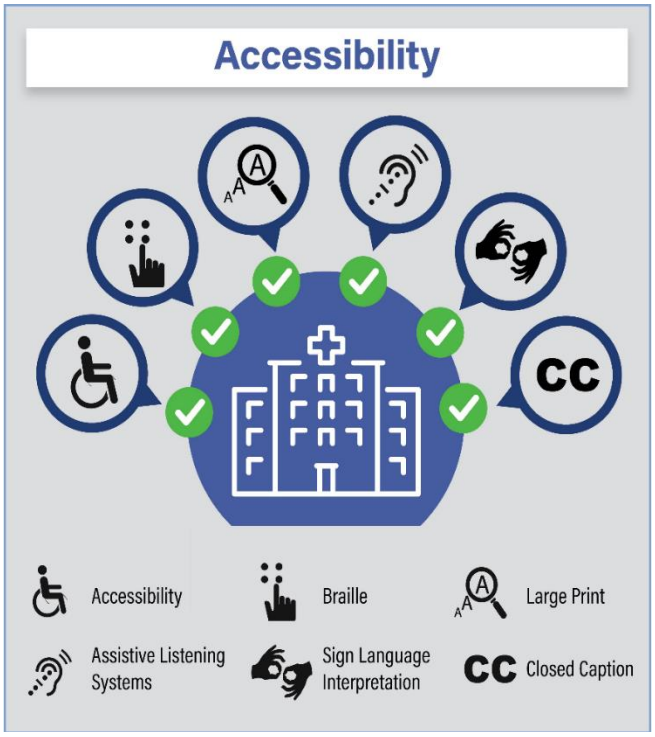


Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations.

The information desk staff also reported using writing to communicate with individuals with hearing impairments; however, they were unable to use basic sign language. Although the facility offered VA interpreter services, which included sign language, the information desk staff said they did not know how to access it.

Additionally, the OIG noted televisions in multiple common areas did not consistently use closed captions to accommodate individuals with hearing impairments. The OIG requests facility leaders to consider using closed captioning on common area televisions.

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

[34] 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.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[35]

The OIG noted from a questionnaire response that the facility had two toxic exposure screening navigators; however, one navigator was only temporarily serving in the role. The OIG interviewed the permanent navigator, who explained that leaders had recruited and selected a clinician to replace the temporary navigator but paused the hiring process in response to VHA's guidance related to budget and staffing reductions.[36] Although the navigators had other primary duties, one of them reported receiving adequate support from leaders to complete the navigator responsibilities. The OIG reviewed facility outreach information and learned the navigators contacted enrolled veterans who had not received care at the facility in over two years to complete toxic exposure screenings and, if veterans chose, coordinate primary care appointments.

Repeat Findings

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

The OIG reviewed the facility's report of the top 10 environment of care deficiencies for FY 2023 and noted stained ceiling tiles listed. The OIG also observed stained ceiling tiles in multiple locations during its general inspection. The Chief of Engineering explained that staff had not consistently reported the damaged tiles to the appropriate staff who would be able to resolve the deficiency. Service leaders said they were aware of the issue and addressed it by conducting environmental rounds and encouraging staff to use the electronic reporting process

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

[36] Under Secretary for Health, "VHA FY 2024 Hiring and Attrition Approach," memorandum.

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

on the facility's intranet site to report deficiencies in real time.[38] The OIG did not make a recommendation because leaders were aware of the problem and had taken steps to address it.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected several clinical and nonclinical areas and found them generally clean and well maintained.[39] In the clinical areas inspected, the OIG observed clear exit paths, secure supply rooms, and biohazard signs posted on soiled utility room doors. However, the OIG also noticed dust on the bottom of two examination tables in the primary care clinic, which staff immediately cleaned. The Chief of Environmental Management Services explained that staffing was a challenge and the number of authorized positions had decreased; therefore, staff from the Compensated Work Therapy Program clean the facility's common areas.[40] Facility leaders also discussed other staffing challenges that included multiple staff using unplanned leave, a high turnover rate, and a hiring process that took approximately four months.

Additionally, the OIG found supplies stored outside of the standard supply room, some of which were expired and could result in staff's unintended use.[41] For example, staff created bins with supplies that were closer to where they used them and did not have a process for checking expiration dates. The OIG recommends facility leaders assess storage locations that are outside of standard supply rooms and implement a process to ensure staff remove expired supplies.

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.

[38] Environmental rounds "are recurring facility tours used to manage environmental risk through the pro-active identification of unsafe conditions or non-compliance." VHA Directive 1608(1).

[39] The facility did not have inpatient medical/surgical areas.

[40] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry, and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers." "Compensated Work Therapy," Department of Veterans Affairs, accessed August 15, 2024, https://www.va.gov/health/cwt.

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

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.[42] 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.[43] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The Acting Chief of Staff reported working to comply with the July 2023 update to VHA Directive 1088. The directive allowed facilities 6 to 12 months to create a local policy and service-level workflows, which describe the team member roles in the process for communicating test results to providers and patients.[44] The Acting Chief of Staff shared drafts of their local policy, an associated standard operating procedure, and a service-level workflow. The OIG noted various elements outlined in the directive were not yet in the draft policy, and the acting chief reported planning to incorporate all required elements into the final version prior to the deadline.

The Radiology Manager said the electronic health record system generated automatic alerts to ordering providers for all test results requiring action, or to a designee if the ordering provider was unavailable. The Local Service Line Manager for Primary Care described methods providers used to sort alerts to address more urgent results first. The manager added that Veterans Integrated Service Network (VISN) staff educated facility staff about managing alert settings to reduce the number of duplicate alerts.[45] The manager also explained service-level leaders reviewed a report that identified providers with unaddressed alerts at least weekly.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[46] The OIG evaluated previous facility action plans in response to

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

[43] 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.

[44] VHA Directive 1088(1).

[45] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Services Networks (VISNs)," Department of Veterans Affairs, accessed May 21, 2024, https://www.va.gov/HEALTH/visns.asp.

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

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

At the time of the site visit, a recommendation from a September 2021 OIG healthcare inspection report that staff complete required disruptive behavior training remained open.[47] The Acting Chief of Staff explained the facility had recently reached six consecutive months of sustained improvement. The OIG confirmed the improvement and closed the recommendation following the visit.

Quality management staff described tracking improvement actions, including those related to prior oversight findings, through committee meetings. For example, the Patient Safety Manager and System Redesign Specialist track improvement actions and present them at the monthly Quality, Safety, Value Committee meeting, which leaders attend.

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.[48] 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.[49] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality management staff stated the facility's continuous learning process starts with daily huddles that include executive leaders, service-level leaders, and frontline staff. They explained that employees attending these huddles present identified deficiencies, discuss actions to address the deficiencies, and share lessons learned. The Local Service Line Manager for Primary Care added that service-level leaders also disseminate the information to frontline staff through electronic messaging.

Further, the Associate Director Patient Care Services/Nurse Executive explained leaders hold biweekly patient safety town hall meetings, where they inform staff about issues and process improvements as part of continuous learning. The Acting Chief of Staff described modifying governance approaches to incorporate more frontline staff as active stakeholders in process changes. The System Redesign Specialist reported holding a quality management healthcare fair in which quality management staff visited community-based outpatient clinics in October 2023 to educate staff on quality improvement processes.

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[47] VA OIG, *Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System in Leeds*, Report No. 21-00263-246, September 14, 2021.

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

[49] VHA Directive 1050.01(1).

The Associate Director Patient Care Services/Nurse Executive described reviewing research to support the development of a second-victim trauma support program as part of the facility's HRO journey. According to The Joint Commission, when a healthcare provider is directly involved in an adverse event with a patient, they can become a second victim of the event, which "can harm the emotional and physical health of the individual and subsequently compromise patient safety."[50]

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[51] 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.[52] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[53] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, the Local Service Line Manager for Primary Care confirmed that the facility had 26 primary care teams and vacancies in three primary care provider positions, which were being filled. The manager explained that one provider was scheduled to start in October 2024, another in November 2024, and staff were interviewing for the third position. When the new providers start, the facility will have 29 primary care teams. The Primary

[50] Adverse events are defined as "untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm or potential harm directly associated with care or services delivered by VA providers." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018; "Quick Safety Issue 39: Supporting Second Victims," The Joint Commission, accessed July 17, 2024, https://www.jointcommission.org/resources. Merriam-Webster dictionary defines iatrogenic as "induced unintentionally by a physician or surgeon or by medical treatment or diagnostic procedures." *Merriam-Webster*, "Iatrogenic," accessed December 9, 2024, https://www.merriam-webster.com/dictionary/iatrogenic.

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

[52] 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).

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

Care Service also had a shortage of four registered nurses, but the service line manager reported that a sick call team (a team of staff who are available to work when primary care teams have staff out sick, or positions are vacant) generally covers those positions temporarily. The manager added that staffing shortages had not affected patient care or wait times.

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.[54] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[55]

To maintain optimal panel sizes and a manageable staff workload, the Local Service Line Manager for Primary Care reported monitoring a daily panel management report so they can adjust work, for instance, when a provider is out sick. The manager also explained that sick call teams are available for walk-in patients, which alleviated some of the workload for staff with large panel sizes.

The Local Service Line Manager for Primary Care said multiple primary care staff were on leave at the time of the OIG site visit and it was sometimes difficult to predict what coverage would be needed to ensure all primary care teams were appropriately staffed on a given day. In addition to the sick call teams, the manager said medical providers who are not assigned a full panel help with coverage. Both the manager and primary care staff reported that panel size and workload are generally adequate.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[56] 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.

During interviews, primary care staff said service leaders were supportive and communicated effectively through daily huddles. The Local Service Line Manager for Primary Care reported sending out a weekly newsletter to communicate important issues to primary care staff.

The Local Service Line Manager for Primary Care shared two examples of performance improvement projects. One was a primary care expansion project in which a nurse contacted veterans who had not seen a provider recently. At the time of the OIG site visit, the nurse had contacted 5,441 veterans, and 2,598 of them had accepted appointments. The second project

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

[55] VHA Directive 1406(1).

[56] VHA Handbook 1101.10(2).

involved increasing use of VA's Whole Health Program.[57] Staff asked veterans to identify health issues important to them and then met with a Whole Health coach, who helped determine which services would best meet their needs. Staff reported increased use of Whole Health services since the project began.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that veteran enrollment decreased slightly from peak enrollment in FY 2021 to January 2024. Leaders reported that, overall, the PACT Act had little effect on patient appointment wait times or primary care delivery.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[58]

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).[59] VA uses the Department of

[57] Whole Health is VA's approach to care "that supports your health and well-being." "Whole Health centers around **what matters to you**, not what is the matter with you." "Whole Health," Department of Veterans Affairs, accessed July 30, 2024, https://www.va.gov/wholehealth/.

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

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

Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[60]

The program did not meet the HCHV 5 target in FY 2023. The HCHV supervisor explained the program only started at the facility in May 2023, and the outreach team was not fully staffed and trained until fall of that year. The supervisor added that other facility homeless programs conducted many of the veteran care responsibilities before the HCHV program started. The program met the target in the second quarter of FY 2024. The supervisor described a goal to provide staff with tablet computers to facilitate real-time enrollment of veterans and avoid reliance on paper documents that then need to be input into the computer system.

Program staff explained they receive referrals from facility staff, community partners, the National Center for Homeless Veterans hotline, and from veterans themselves. Staff listed the community partners as shelters, food pantries, police departments, behavioral health agencies, senior centers, veteran service officers, community action centers, and libraries.

Program staff also described engaging with homeless veterans through their office located at the facility. The staff explained that during business hours, homeless veterans could come to the office for information on the homeless programs, help finding shelter, and to retrieve items from the resource room. The OIG observed the resource room and found it well stocked with items such as coats, sleeping bags, hand warmers, backpacks, boots, blankets, personal toiletries, and tents. Staff stated the facility's Voluntary Services staff help stock the resource room and coordinate receipt of community donations, including student-crafted veteran care gift bags.

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

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[61]

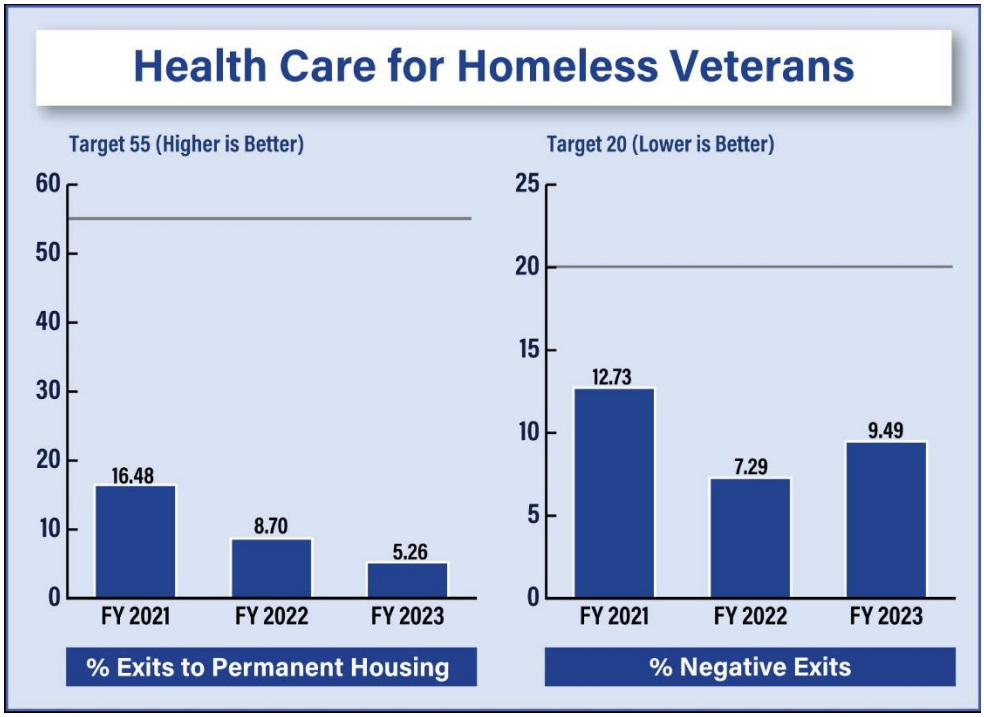

Figure 9. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program did not meet the HCHV1 target for FYs 2021 through 2023 but did meet the HCHV2 target all three FYs. The supervisor discussed barriers to housing, including low inventory and high rental costs. Moreover, the supervisor explained housing vouchers were between $1,300 and $1,500 to cover monthly rent, but one-bedroom apartments in the area cost around $2,000 a month. The supervisor told the OIG the program also had contracted emergency shelter beds for homeless veterans and those with severe mental illness. Additionally, the supervisor stated staff help veterans use Housing and Urban Development–Veterans Affairs Supportive Housing vouchers and refer them for other housing and financial resources, when needed.

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

Staff stated they coordinate veterans' access to VA services and provide case management services. Additionally, staff help veterans apply for financial benefits through the state and refer them to facility primary care providers or community clinics, facilitate mental health or substance use intake appointments, and connect them with a local transit program that taught individuals how to use public transportation.

Staff also described a gap in services for aging veterans, stating that over half of enrolled veterans are elderly and staff had difficulties finding them housing placements because of their physical care needs. The supervisor also spoke of difficulties finding shelter and transitional housing for veterans' partners and families because a partner was not a veteran, or the housing program did not accommodate families.

In Worcester County, where the facility has an outpatient clinic, staff reported the transitional housing program had lost about 115 beds and emergency shelters were full. Staff attended weekly meetings with community partners who support homeless individuals in the county to discuss the shortages in resources, like shelters. At the time of the OIG visit, the supervisor stated they were working to secure contracts for 36 emergency housing beds in Worcester.

Veterans Justice Program

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

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[64] The Veterans Justice Program did not meet the performance measure target in FY 2023. The Veterans Justice Outreach Coordinator attributed it to staff not consistently entering veterans' information into the national reporting database to be included in the count. The coordinator identified the issue in January 2024, notified the program supervisor, and stated staff improved their documentation the following year.

The coordinator explained staff covered assigned district courts and jails, and there were no federal prisons in their service area. The coordinator stated many of the program's referrals were

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

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

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

from the Massachusetts Department of Probation; however, they also received referrals from facility staff, jails, and police departments.

Meeting Veteran Needs

The facility offered legal services for veterans through an agreement with a county legal aid office. Additionally, the Veterans Justice Outreach Coordinator explained there were two veterans treatment courts, where staff could complete intake assessments for veterans before their arraignments and coordinate treatment referrals.[65] According to the coordinator, staff support veterans who participate in the veterans treatment court program, which included 18 months of supervision, weekly court appearances, and work with mentors and the probation department. Veterans who completed the program often had more favorable resolutions to their cases.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[66] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[67]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[68] The program did not meet the performance measure target for FYs 2021 through 2023. The program supervisor reported reviewing program data about a year previously to determine why the program was not meeting the target and identifying a high number of veterans who left the

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

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

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

[68] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

program due to an increased income, incarceration, or relocation and were no longer eligible or needed the housing vouchers. The supervisor stated they had plenty of housing vouchers but was unsure if there were enough affordable housing options to place veterans any faster. At the time of the site visit, the supervisor told the OIG there were about 35 veterans interested in the program and about half were gathering housing application documents.

The supervisor explained staff identify veterans through the point-in-time count, community homeless provider meetings, and street outreach and receive referrals from the National Call Center for Homeless Veterans, the transitional housing program, community providers, and other facility homeless programs.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[69] The program did not meet the target for FY 2023. The program supervisor attributed this to lacking a program employment specialist for several years; however, they hired one in June 2023. The OIG spoke to the Employment Specialist, who reported helping veterans find jobs by working with community employers and participating in homeless program events and local job fairs. Additionally, the supervisor stated the facility's Vocational Rehabilitation Service had a walk-in clinic where staff helped veterans find employment.

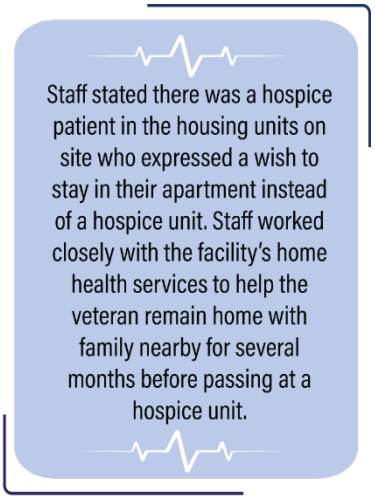

Figure 10. *Best practice for outreach and veteran engagement. Source: OIG analysis of interview.*

The supervisor described 44 rental housing units on the facility's campus built by a nonprofit organization in partnership with VA. The supervisor reported that facility leaders changed the eligibility for the rental housing units from all veterans with housing vouchers to those who are frail and elderly in calendar year 2023. To accommodate the needs of frail and elderly veterans, the supervisor said the program received approval to hire a nurse, certified nursing assistant, occupational therapist, and peer support specialist. At the time of the OIG site visit, the supervisor reported that only the Peer Support Specialist had started, and staff were not recruiting for the nurse and certified nursing assistant positions because of the FY 2024 VHA guidance related to staffing reductions.

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

The supervisor said the Peer Support Specialist helped elderly veterans with social isolation. For example, the specialist established a relationship with an elderly veteran who was not engaging with others, introduced them to local senior center staff, and initially accompanied them on the bus to the center. The supervisor stated the veteran began visiting the senior center regularly and established a sense of community.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided a recommendation on a systemic issue that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's finding and recommendation 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

Finding: Staff maintained some supplies outside of the standard supply room, some of which were expired. Staff stored supplies in bins close to where they used them and did not check expiration dates.

Recommendation 1

The OIG recommends facility leaders assess storage locations that are outside of standard supply rooms and implement a process to ensure staff remove expired supplies.

_X_ Concur

____ Nonconcur

Target date for completion: March 31, 2025

Director Comments

The area in question observed by OIG was the Women's Health clinic "satellite" storage area. The process for procurement, storage, and use of supplies was reviewed by Chief of Quality Management (QM) in conjunction with the Medical Supply Manager, Supply Chain Management leader, System Redesign Supervisor, and Women's Health Program Manager. The discussion focused on improving and reducing the amount of supplies being removed from designated storage supply rooms, preventing future findings related to expired supplies in exam rooms and how clinical staff is managing supplies outside of dedicated medical supply rooms.

Prior to the OIG inspection (May 2024), a clinical area staff member had undertaken a process improvement project of reducing the amount of time staff spend searching for medical supplies due to the inconsistent storage of supplies amongst multiple locations. This project has since finalized and is now being revisited to include proper storage as well as consistent inventory inspection of supplies. The initial project showed significant improvement and is slated to be rolled out amongst multiple areas. The project has been updated to include a detailed SOP, which includes, location(s), rotation, and inspection of supplies to ensure expired supplies are removed timely to ensure sustainability. Monthly audits per unit managers or designee will be performed in conjunction with the Environment of Care (EOC) and QM rounding. The action plan includes this updated process which will benefit clinical staff, nursing, and logistics; and includes providing education on proper procedures for supply management, identifying expiration dates, and proper disposal of expired items.

Members of the QM team who currently participate in scheduled EOC rounding (Patient Safety Manager, Accreditation Specialist, any others as need arises) will add additional level of oversite during these rounds to specifically review supplies within the determined scheduled rounding site(s).

In addition to the schedule Environmental of Care rounding, members of the QM department will inspect 30 different clinical areas/exam rooms monthly to check for expired supplies. These rounds and findings will be tracked using a log worksheet to document these audits. Reports will be tracked though the Environment of Care Committee (CEOC), which reports to Healthcare Operations Council (HOC). Reports will continue until six (6) consecutive months of 90% compliance and then quarterly. Inspections will include checking exam room/clinical space supplies for expired items.

The Chief of Quality management, or designee will be responsible for the corrective action(s) and ongoing compliance associated with this finding.

Appendix A: Methodology

Inspection Processes

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

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from July 9 through 11, 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

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

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 21, 2025

From: Director, VISN 1: VA New England Healthcare System (10N1)

Subj: Healthcare Facility Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

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

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

1. Thank you for the opportunity to review and comment on the draft report regarding the healthcare inspection report at the VA Central Western Massachusetts Healthcare System in Leeds. The VA New England Healthcare System is committed to providing exceptional healthcare to Veterans. This includes building a Just Culture that supports the prevention of patient harm and continuous process improvement as a High Reliability Organization.
2. I thank the OIG team for their recommendation which identified areas for improvement.
3. The leadership teams at VA Central Western Massachusetts Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

(Original signed by:)

Ryan Lilly, MPA
VISN 1 Network Director
VA New England Healthcare System

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: January 16, 2025

From: Interim Executive Director, VA Central Western Massachusetts Healthcare System (CWMHCS) (631)

Subj: Office of Inspector General (OIG) Draft Report: Healthcare Facility Inspection of the VA Central Western Massachusetts Healthcare System in Leeds

To: Veterans Integrated Service Network (VISN) 1 Director, VA New England Healthcare System (10N01)

1. Thank you for the opportunity to review and comment on the draft report regarding the Healthcare Facility Inspection that was conducted at the VA Central Western Massachusetts Healthcare System in Leeds, MA in July of 2024.
2. I have reviewed and concurred with 1 recommendation and will ensure the corrective actions are completed and sustained, as described in the attachment.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans. We will continue to partner with the OIG, VISN, and CWM VA HCS Leadership to implement corrective actions to demonstrate our dedication to providing exceptional service to the Veterans we serve.
4. Comments or questions regarding the contents of this memorandum may be directed to the Chief of Quality Management for the VA Central Western Massachusetts Healthcare System.

(Original signed by:)

Jonathan D. Kerr
Interim Executive Director, VA CWM

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Director, VA Central Western Massachusetts Healthcare System (631)

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