US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Lovell Federal Healthcare System in North Chicago, Illinois

Healthcare Facility Inspection	24-00614-72	March 12, 2026

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

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Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the Lovell Federal Healthcare System (the facility) from September 23 through 26, 2024.

The facility has been an integrated VA and Department of Defense healthcare center since October 2010 and, in fiscal year 2023, served approximately 40,000 Navy recruits and 50,000 enrolled veterans.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The OIG examined system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.

  Environment of Care. The OIG team inspected the main entrance and patient care areas. The team discovered eyewash stations with missing inspections, wheelchairs with damaged armrests, and improperly stored high-level disinfected endoscopes. These were also findings from previous inspections.[3] Staff provided information to the OIG in December 2025 that showed they had resolved the eyewash station and wheelchair issues but still had not properly stored endoscopes. The OIG issued a recommendation. In response, the Director stated that staff purchased an additional storage cabinet and conducted weekly audits to make sure the endoscopes could hang properly, and therefore, the OIG closed the recommendation before the report was published.

- **Patient Safety.** The OIG assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. Leaders had not developed service-level workflows that outline the communication process, as required by VHA Directive 1088(1).[4] Staff provided

[1] A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA OIG, *Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois*, Report No. 20-00064-238, August 27, 2020; The Joint Commission, *The Joint Commission Final Accreditation Report for CAPT James A. Lovell Federal Health Care Center*, January 19, 2024.

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

updated information in December 2025, but the OIG determined they only developed a workflow for Primary Care and made a recommendation. In response, the Director stated the Chief Medical Executive worked with section chiefs to develop the remaining workflows. Additionally, quality management staff did not share External Peer Review Program data for test result communication with executive leaders, which could prevent them from addressing issues.[5] The OIG made a recommendation. In response, the Director reported developing a process for staff to report data to the Quality Council, which executive leaders attend.

- **Primary Care.** The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[6] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The OIG assessed programs that offer medical care and social support services to vulnerable veterans who are homeless and recently incarcerated. The OIG made no recommendations.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiency of VA programs and services that improve the health and welfare of veterans and their families.

What the OIG Recommended

1. Executive leaders ensure staff properly store endoscopes.
2. The Medical Center Director ensures each service develops a workflow for the communication of test results.
3. The Medical Center Director ensures quality management staff report deficiencies identified from the External Peer Review Program to executive leaders and staff take corrective actions as needed.

[5] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "identified deficiencies are addressed." VHA Directive 1088(1).

[6] VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the inspection recommendations and provided acceptable improvement plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments). The OIG continued communication with VHA regarding the findings, which resulted in the closure of recommendation 1. For the open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

DoD	Department of Defense
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires sustained and thorough OIG scrutiny to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each inspection focuses on five domains: culture, environment of care, patient safety, primary care, and a veteran-centered safety net (comprising programs for veterans experiencing homelessness or recent incarceration).

Healthcare Facility Inspection reports provide insight into the experiences of staff working in VHA facilities and veterans receiving care there. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take.

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

In 2018, VHA launched efforts to become a high reliability organization (HRO) and set goals to enhance accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to strengthen the culture of patient safety and high-quality care in medical facilities.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

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[1] "About VHA," Department of Veterans Affairs, last updated January 20, 2025, https://www.va.gov/health/aboutvha.

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

[3] "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.)

Inspection Domains

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

The Lovell Federal Healthcare System (the facility) has been an integrated VA and Department of Defense (DoD) healthcare center since October 2010.[4] The facility consists of two main sites: the West Campus provides VA inpatient, primary, and specialty care services, and the East Campus houses DoD operations. In fiscal year (FY) 2023, the facility's budget was over $677 million, and staff served approximately 40,000 Navy recruits and 50,000 enrolled veterans. The facility had 88 hospital, 134 community living center, and 99 domiciliary beds.[5]

Figure 3. *Facility photo.*
Source: Photo taken by OIG inspector.

The OIG inspected the facility from September 23 through 26, 2024. The executive leaders referred to throughout this report include both VA and DoD personnel. VA leaders include the Medical Center Director (Director); Chief Medical Executive; Associate Director, Resources; and Associate Director for Patient Care Services/Chief Nurse Executive. DoD leaders consist of the Deputy Director, Lovell Federal Health Care Center (FHCC)/Commanding Officer Navy Medical Readiness and Training Command (NMRTC) Great Lakes; Executive Officer; Command Master Chief, NMRTC Great Lakes; Deputy Director Patient Care Services Lovell FHCC, Navy Nurse Executive NMRTC Great Lakes; and Associate Director, Facility Support/Director for Administration. Executive leaders said the Director joined the executive team in October 2018, and the newest team member, the Deputy Director, started in July 2024.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[6] The OIG team

[4] A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).

[5] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, last updated June 3, 2025, https://www.va.gov/Community_Living_Centers. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, last updated May 1, 2025, https://www.va.gov/homeless.

[6] 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.

administered its own facility-wide questionnaire. The team also interviewed leaders and employees and considered data from patient advocates and veterans' feedback.[7]

System Shocks

Executive leaders identified the implementation of the Oracle electronic health record as a system shock; many respondents to the OIG questionnaire agreed.[8] In March 2024, the facility became the sixth VA medical facility to implement Oracle. Leaders explained that they deployed two different versions, and staff use a version based on where they provide care. For example, staff use Millennium at VA care locations on the West Campus, and Genesis at DoD care locations on the East Campus.

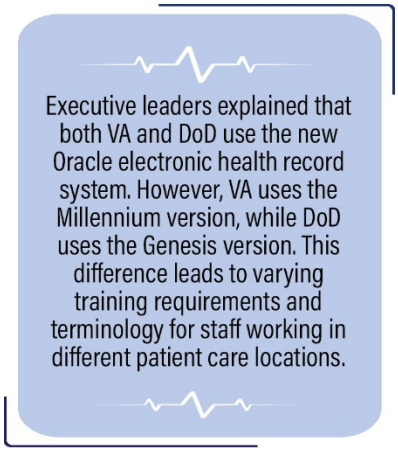

Figure 4. *Facility system shocks. Source: OIG interview with executive leaders.*

Executive leaders shared that staff experienced similar issues as other VA facilities that implemented Oracle, such as difficulty capturing VA workload. Staff also identified several challenges that affected clinical and administrative workflows. These included difficulties with appointment scheduling; extensive, version-specific training requirements; inconsistencies between Millenium and Genesis; and issues with medication management that posed risks for continuity of care.

Facility leaders stated they supported staff and maintained patient safety by implementing temporary workarounds, standardizing processes, and developing quick reference guides for the new system. Leaders also increased communication with staff, coordinated with VA and Oracle development teams, and escalated unresolved issues to national leaders. The Director emphasized that no significant adverse patient safety events occurred because of the system rollout.

On December 11, 2025, the OIG interviewed facility leaders, who reported significant progress since the March 2024 implementation. Leaders said they addressed early challenges through staff training and system updates. They also refined clinical and administrative processes and improved the integration of Millenium and Genesis.

[7] Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," Department of Veterans Affairs, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[8] "VA's Electronic Health Record Modernization (EHRM) program is managing the transition from VA's current medical record system, Veterans Health Information Systems and Technology Architecture (VistA), to the Federal EHR," by partnering with a commercial vendor, Oracle Health. "Frequently Asked Questions: What is the Electronic Health Record Modernization Program?," VA EHR Modernization, last updated February 11, 2026, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

Employee Experiences

In response to OIG's questionnaire, respondents indicated that leaders' communication is clear and frequent, but not useful. Respondents also indicated they generally feel comfortable reporting safety concerns and suggesting ways to improve their work environment.

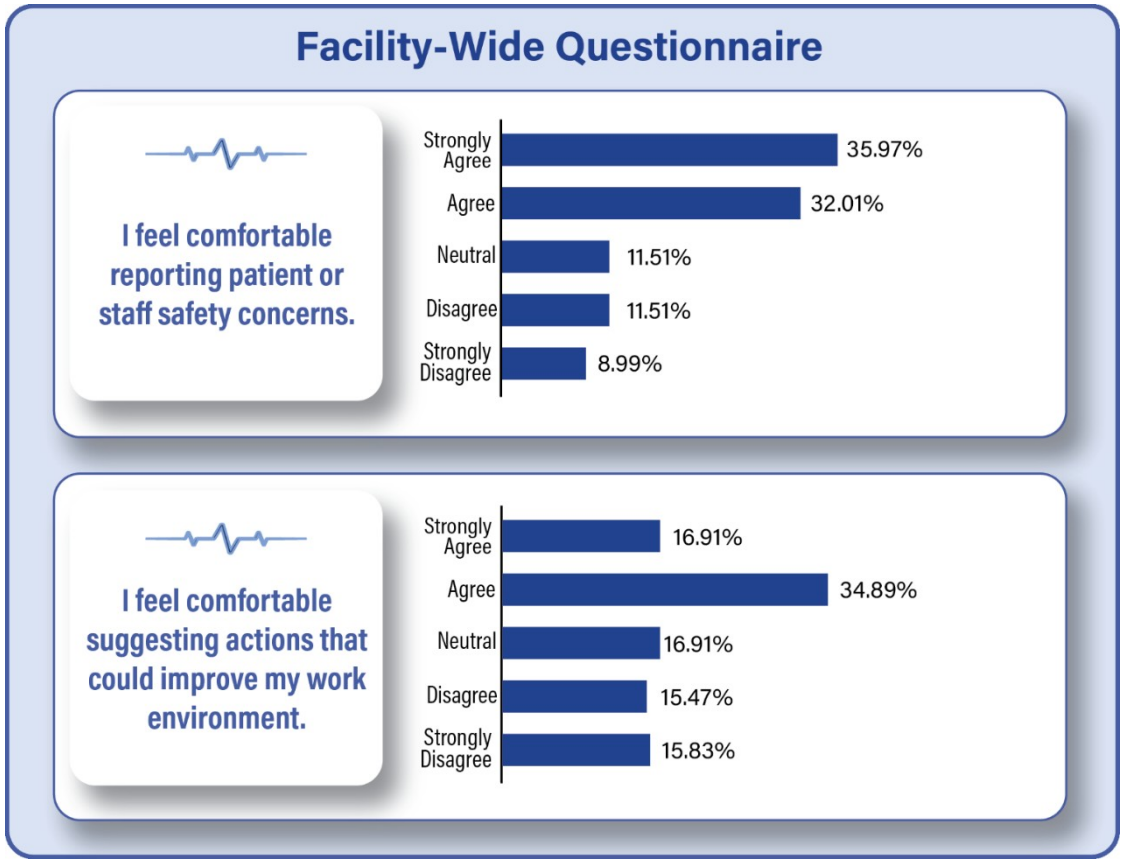

Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The executive leaders said all facility leaders meet with employees daily to hear their concerns and work with mid-level managers to address them. They found the tiered huddle system helpful for addressing employees' concerns.[9] However, while the resolutions are often communicated to a specific department, they rarely reach the individuals who initially raised the issue. To

[9] "Tiered huddles consist of a series of brief (typically no more than 15 minutes), focused, and transparent forums including frontline staff all the way to senior leadership to proactively identify, share, and address safety concerns, staffing levels, resource allocation, operational issues, and more across an entire organization or healthcare system." Naseema B. Merchant, et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000.

overcome this barrier, the leaders communicated through various methods, such as emails, the VA emergency announcement system, town halls, and a weekly bulletin.[10]

The executive leaders also recognized ongoing communication challenges between VA and DoD employees, particularly regarding DoD's limited access to VA databases that store pertinent information. Additionally, leaders said DoD employees are often unable to open secure VA emails. Therefore, they worked with Microsoft, VA, and DoD information and technology support services to resolve the issue.

Executive leaders reported that provider burnout has increased due to staffing shortages and rising workloads. They attributed part of this burden to a recent surge in military recruits, many of whom entered under medical waivers granted by the Navy. These waivers have led to more complex medical needs during the recruits' 10-week boot camp, and increased demands on both DoD and VA providers. While DoD primary care providers primarily treat recruits, those requiring specialty services—such as mental health, inpatient, or emergency care—may be referred to VA care locations. Leaders noted that employees prioritize recruits for specialty appointments, resulting in more veterans being referred to community care.[11]

Veteran Experiences

Patient advocates' responses to the OIG questionnaire generally indicated that veterans provide feedback to executive leaders, and the leaders are responsive to their concerns. The executive leaders reported they obtain information about the veterans' experiences from multiple sources, such as town halls; the Stakeholders Advisory Council, which consists of various veterans groups; and community partners. Leaders said they use the information to improve veterans' experiences. They also said results from a National Patient Experience Evaluation revealed that veterans often want to switch providers, and leaders implemented a process where staff contact them to understand why, as part of the facility's service recovery process.[12]

[10] The VA Emergency Alerting and Accountability System sends rapid and widespread notifications to employees, contractors, and affiliates. Department of Veterans Affairs, "VA Emergency Alerting and Accountability System (VA EAAS)," (privacy impact assessment), October 1, 2022.

[11] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, last updated June 21, 2024, https://www.va.gov/communitycare.

[12] Service recovery is "the process used to recover dissatisfied or lost customers or patients by acknowledging a failure in service experience and an agreement to making amends for the failure in customer service." Veterans Health Administration, Office of Patient Advocacy, *Veteran Centered Complaint Resolution Guidebook*, January 2023.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[13] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

OIG inspectors examined the facility's compliance with key VA and VHA guidelines and standards, as well as Architectural Barriers Act and Joint Commission standards. They also considered best practice principles from academic literature.[14]

General Inspection

The OIG team located the facility using the directions on its website and observed multiple parking options and signs that made it easy to locate the main entrance (West Campus). The team also observed valet parking services, a public transit location, and a shuttle service that transported veterans from parking lots to the facility.

The OIG noted VA and DoD staff at the information desk who assisted veterans with directions. The inspection team also found it easy to locate clinical and nonclinical areas using directional signs and the Med Maps wayfinding mobile application.[15]

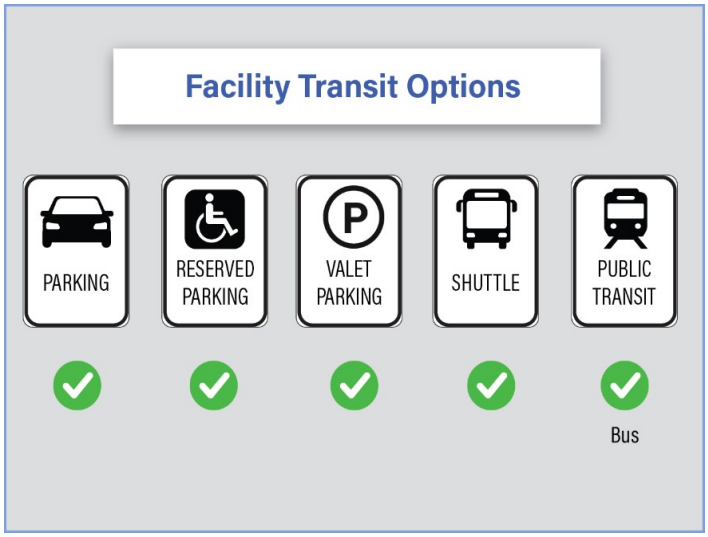

Figure 6. *Transit options for arriving at the facility. Source: OIG observations.*

[13] "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[14] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

[15] "Captain James A. Lovell Federal Health Care Center," Med Maps, accessed October 23, 2024, https://interactive.medmaps.com/site/lovellfhcc.

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

The parking garages included braille and textured walking surfaces at crosswalk intersections. Although staff at the main entrance had not received basic sign language training, they explained how they assist veterans with sensory impairments with navigating the area, such as providing directions or escorting them to their appointment.

The OIG inspected the community living center, primary care clinic, emergency department, intensive care unit, and medical surgical unit and found them to be generally clean, well-lit, and clutter free. However, there were problems with eyewash stations, wheelchairs, and endoscopes, which the OIG noted as deficiencies during the previous inspection in January 2020.[16] The Joint Commission also identified issues with eyewash stations in a January 2024 survey.[17]

The OIG observed several eyewash stations in a dental clinic on the East Campus either missing weekly inspections, as required by VHA Directive 7704, or needing repairs.[18] If eyewash stations do not function properly in an emergency, staff may be injured. Dental staff acknowledged the finding but could not provide a reason for noncompliance. The chief of facilities management reported being responsible for the West Campus only, which may have contributed to staff not addressing deficiencies on the East Campus.[19]

The OIG also found wheelchairs with exposed foam padding on the armrests. According to The Joint Commission's Standards Manual, healthcare facilities must ensure furnishings and equipment are safe and in good repair.[20] Exposed padding cannot be sanitized to prevent cross-contamination between patients. Staff acknowledged that while they have a process to report

[16] An endoscope is used "for visualizing the interior of a hollow organ or part (such as the bladder or esophagus) for diagnostic or therapeutic purposes." *Merriam-Webster*, "Endoscope," last updated January 2, 2026, https://www.merriam-webster.com/endoscope. VA OIG, *Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois*, Report No. 20-00064-238, August 27, 2020.

[17] The Joint Commission, *The Joint Commission Final Accreditation Report for CAPT James A. Lovell Federal Health Care Center*, January 19, 2024.

[18] VHA Directive 7704, *Emergency Eyewash and Shower Program,* October 12, 2021.

[19] The chief of facilities management said the naval base team is responsible for correcting environment of care deficiencies on the East Campus.

[20] The Joint Commission, *Standards Manual,* EC.02.06.01.

wheelchairs that require either repair or replacement, they have challenges tracking wheelchairs across different areas.

Staff submitted information in December 2025 that showed they had corrected the eyewash station and wheelchair issues. Therefore, the OIG did not make a recommendation.

Further, the OIG found high-level disinfected endoscopes, which are reusable medical devices that require a specific cleaning process, touching other scopes.[21] The Association for the Advancement of Medical Instrumentation requires that high-level disinfected endoscopes be stored in a cabinet that allows them to hang without touching other scopes to keep them clean and prevent contamination.[22] The OIG reviewed updated information provided by staff in December 2025 and determined they had not corrected this finding.

Recommendation 1

Executive leaders ensure staff properly store endoscopes.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The most recent VISN Sterile Processing Service (SPS) audit was conducted from January 27, 2025 to January 31, 2025. The following improvements were made following this audit: tip protectors are now in place on all endoscopes and an additional environmentally controlled storage cabinet was purchased to provide additional spacing for endoscopes (the scopes were reconfigured in the cabinets with a 5 space holder and a diagram was also posted with steps). All staff were reeducated on scope handling.

Additionally, the SPS department conducts weekly audits of the endoscopes. There were no findings of endoscopes touching for the last eight months of weekly audits (100% compliance for the last eight months of weekly audits: May 2025–December 2025). These audit results have been reported at the facility Reusable Medical Equipment (RME) Committee.

[21] VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[22] Association for the Advancement of Medical Instrumentation, *ANSI* [*American National Standards Institute] / AAMI [Association for the Advancement of Medical Instrumentation], Flexible and Semi-Rigid Endoscope Processing in Health Care Facilities*, *ST91:2021*, 2022.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The OIG team examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results; the sustainability of changes made by leaders in response to previous oversight recommendations, facility investigations, and improvement projects. The team also assessed how facility staff implemented continuous learning processes.

Communication of Urgent, Noncritical Test Results

At the time of the inspection in September 2024, leaders had developed a local policy for the communication of test results, but staff had not created service-level workflows that describe team members' roles in the process, as required by VHA Directive 1088(1).[23] Facility leaders provided updated information in December 2025, but the OIG determined that staff had only developed a workflow for Primary Care.

Recommendation 2

The Medical Center Director ensures each service develops a workflow for the communication of test results.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2026

Director Comments

To date, 5 out of 5 medical services have developed a workflow for the communication of test results. The Chief Medical Executive will ensure the facility has workflows for all services for the communication of test results by February 28, 2026. The Chief Medical Executive is in the process of getting the workflows into the template.

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

Quality management staff said they currently monitor providers' communication of test results to patients through the quarterly External Peer Review Program but only report the results to staff in the area where deficiencies occurred.[24] Executive leaders confirmed they did not receive this information. VHA Directive 1088(1) requires the Director to ensure staff review External Peer Review Program reports quarterly and address deficiencies.[25] When staff do not share data with executive leaders, they are not afforded the opportunity to help improve program outcomes. In December 2025, staff provided updated information to the OIG; however, it did not show that leaders corrected this deficiency.

Recommendation 3

The Medical Center Director ensures quality management staff report deficiencies identified from the External Peer Review Program to executive leaders, and staff take corrective actions as needed.

_X_ Concur

____ Nonconcur

Target date for completion: August 1, 2026

Director Comments

EPRP data has been reported quarterly to the Quality Council. Beginning in January 2026, any deficiencies identified through the External Peer Review Program (EPRP) are being addressed by the facility's EPRP Committee. A delegate appointed by the Chief Medical Executive will develop an action plan for these deficiencies. Both the deficiencies and the corresponding corrective action plans will be reported during Quality Council meetings, which is attended by executive leaders. Progress will be monitored through audits to ensure sustainment of six consecutive months, which is expected by July 2026.

Action Plans and Process Improvements

The OIG found no open recommendations related to the communication of test results from the most recent oversight and accreditation surveys.[26] Quality management staff said they did not

[24] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "identified deficiencies are addressed." VHA Directive 1088(1).

[25] VHA Directive 1088(1).

[26] The Joint Commission, *The Joint Commission Final Accreditation Report for CAPT James A. Lovell Federal Health Care Center*; VA OIG, *Comprehensive Healthcare Inspection of the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois*.

complete root cause analyses, identify sentinel events, or conduct institutional disclosures in the past three years related to the communication of abnormal test results.[27]

Quality management staff described their process for addressing oversight recommendations: they help staff develop action plans to resolve findings, conduct audits, and report on action plan compliance for approximately six months to the Quality Council. The patient safety managers added that they identify opportunities for improvement through the Joint Patient Safety Reporting system and share them during patient safety forums and Quality Council meetings.[28]

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2).[29] The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

Primary Care Teams

The facility has 23 primary care teams between the main facility and three outpatient clinics (two in Illinois, and one in Wisconsin). The primary care coordinator reported one vacant primary care provider position at the main facility. The assistant chief medical executive of ambulatory care said 13 providers from the National Electronic Health Record Modernization Supplemental Staffing Unit assist primary care providers with their workload as they adjust to the Oracle electronic health record.[30]

The primary care coordinator reported five vacant medical support associate positions between the Evanston, McHenry, and Kenosha community-based outpatient clinics. According to the

[27] A root cause analysis "is a comprehensive team-based, system level investigation with a formal charter for review of health care adverse events and close calls." "A sentinel event is any patient safety event (not primarily related to the natural course of the patient's illness or underling condition) that results in death, permanent harm or severe temporary harm." VHA Directive 1050.01(1). Institutional disclosure "is a formal process by which facility leader(s), together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

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

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

[30] "The National EHRM [Electronic Health Record Modernization] Supplemental Staffing Unit (NESSU) is a group of VA clinicians who support facilities going live with the new EHR by providing: 1) peer support to help facility employees understand and use the new EHR, 2) direct patient care to offload facility employee work while they adjust to the new EHR, and 3) assistance with manual data migration." PROVEN Hub Newsletter, *Coordinating Hub to Promote Research Optimizing Veteran-centric EHR Networks*, December 2023.

group practice manager, the medical support associate role is an entry-level position, and as these employees gain experience, many move on to higher-paying positions within the federal government. Therefore, primary care leaders host job fairs regularly to support continuous recruitment.

In an interview, a social worker reported being assigned to seven teams, which created challenges with addressing consults in a timely manner. VHA Handbook 1101.10(2) suggests a staffing ratio of one social worker for every two primary care teams to help coordinate health services.[31] The assistant chief medical executive described being aware of the concern and planning to meet with the social workers and their leader to review their assignments and discuss opportunities to improve efficiency.

Primary care team members and leaders said the most significant issues affecting clinic workflow were related to the Oracle electronic health record. Staff emphasized the issues significantly slowed down nurses' and providers' medication review and ordering processes.[32] They also said most providers cannot address patient messages and complete their notes timely due to system-related issues. Providers added that they were overwhelmed with seeing 12 patients per day while learning the new system and dealing with its unresolved issues. Executive leaders were aware of these concerns and had solicited feedback from VHA for resolution.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[33]

[31] VHA Handbook 1101.10(2).

[32] "The medication reconciliation process seeks to maintain and communicate accurate patient medication information. It entails identifying, addressing, and documenting medication discrepancies found in the VA electronic medical record as compared with the information supplied by the patient." VHA Directive 1345, *Medication Reconciliation*, March 9, 2022.

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

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[34] However, this fiscal year (FY 2026), VHA no longer uses this intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services and low-demand safe haven programs.[35] Finally, HCHV2 (negative exits) measured 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."[36]

Program Highlights

- The program coordinator said the program exceeded the HCHV5 target in FY 2023 and clarified that HCHV1 and HCHV2 performance measures did not apply to the facility's homeless program because there are no contracted emergency residential services and low-demand safe haven programs in the area, which are included in those metrics.
- Program staff discussed a walk-in clinic where they assess homeless veterans and refer them for resources, such as health care, clothing, food, and legal services. Staff also said they have close, collaborative relationships with community partners to help veterans with emergency shelter and financial resources. Staff further explained that these same community partners also support the Veterans Justice and Housing and Urban Development–Veterans Affairs Supportive Housing programs.

Housing and Urban Development–Veterans Affairs Supportive Housing

The Housing and Urban Development–Veterans Affairs Supportive Housing program combines Department of Housing and Urban Development rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious

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

[35] VHA sets the target for HCHV1 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*. "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025. Low-demand safe havens are transitional residences with minimal restrictions for veterans with mental health or substance use issues. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

mental illness, physical health diagnoses, and substance use disorders."[37] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[38]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[39]

Program Highlights

- In FY 2023, the program did not meet the HMLS3 target. Program staff reported that after the state of Illinois implemented the Source of Income Law, landlords had to consider the voucher as a source of income, which provided veterans with more housing options. Of note, one of the three counties in the program's service area achieved functional zero for veteran homelessness in 2019 and had sustained it since then.[40]
- The program exceeded the VASH3 target in FY 2023. Staff discussed the program's community employment coordinator, who organizes a weekly job club to help veterans build resumes, apply for jobs, and prepare for interviews.

Veterans Justice Program

VHA's Veterans Justice Program serves veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration.[41] Recognizing incarceration as a strong predictor of homelessness, the program focuses on connecting veterans to VA health care, services, and benefits. VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[42]

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

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

[39] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[40] "Functional zero for veteran homelessness means that fewer veterans are experiencing homelessness than can be routinely housed in a month, with a minimum threshold of 3 veterans." "Functional Zero," Community Solutions, accessed June 6, 2024, https://community.solutions/built-for-zero/functional-zero.

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

[42] 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*.

Program Highlights

- The program did not meet the target in FY 2023. The veterans justice outreach specialist attributed this to difficulty identifying veterans for enrollment because jail representatives do not consistently determine veteran status. As a result, the lists of veterans the specialist receives can be inaccurate. The outreach specialist reported providing brochures to jail representatives to help identify veterans who have not disclosed their military service.
- Program staff said they provided iPads to jails so they can conduct virtual outreach with veterans. The outreach specialist also mentioned the facility's deflection team, which consists of two outreach specialists, a suicide prevention coordinator, and VA police who educate local law enforcement on using the program as an alternative to criminal prosecution for some veterans.[43]

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted an inspection across five domains. The OIG provided recommendations on issues related to the environment of care and test result communication. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 1. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, program leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

[43] "Deflection is when police and other first responders get help for people who have overdosed or have substance use disorders, and is an alternative to arrest or the emergency room." "Law Enforcement and First Responder Deflection Services," Center for Health & Justice at Treatment Alternatives for Safe Communities, accessed January 7, 2025, https://www.centerforhealthandjustice.org/Deflection-Services.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG distributed voluntary questionnaires through the facility's employee mail groups to gain insight and perspective related to the organizational culture. 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.*[1]

Potential limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[2] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from September 23 through 26, 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.[3] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[2] 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.

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

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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 26, 2026

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Healthcare Facility Inspection of the Lovell Federal Healthcare System in North Chicago, Illinois

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Healthcare Facility Inspection of the Lovell Federal Healthcare System in North Chicago, Illinois.
2. I concur with the findings and recommendations identified by OIG, and the corrective action plans submitted by the facility.
3. I would like to thank the OIG inspection team for their review of the Lovell Federal Healthcare System in North Chicago, Illinois.

(Original signed by:)

Daniel S. Zomchek, PhD
Network Director, VISN 12

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: January 21, 2026

From: Director, Lovell Federal Healthcare System (556)

Subj: Healthcare Facility Inspection of the Lovell Federal Healthcare System in North Chicago, Illinois

To: Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Healthcare Facility Inspection of the Lovell Federal Healthcare System in North Chicago, Illinois.
2. A corrective action plan has been implemented as detailed in the attached report.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Robert G. Buckley, MD, MPH, FACEP
Director, Lovell FHCC, North Chicago

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