



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Maine Healthcare System in Augusta

Healthcare Facility
Inspection

25-00244-289

October 5, 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 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 VA Maine Healthcare System (the facility) from July 29 through 31, 2025. Additionally, the OIG team contacted facility staff in January and July 2026 for updates. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to more than 44,000 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 inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG team found the facility's test result communication policy did not align with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, and the facility lacked service-level workflows that explain staff responsibilities in the patient notification process.³ Additionally, the acting Chief of Staff and Associate Director for Patient and Nursing Services did not develop improvement actions after learning about issues with providers communicating test results within time frames required by VHA Directive 1088(1). The OIG made two recommendations to address these issues.

¹ VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 1) Togus VA Medical Center*, updated February 12, 2026.

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

³ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.⁴ The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Chief of Staff and Associate Director for Patient and Nursing Services develop service-level workflows that outline responsibilities in the patient notification process and update the facility's test result communication policy to align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
2. The Chief of Staff and Associate Director for Patient and Nursing Services implement actions based on external peer review data to improve providers' communication of test results to patients, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

⁴ VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments).⁵ The OIG will follow up on the planned actions until they are completed.



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⁵ In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>.

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development-Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Executive Summary	i
Abbreviations	iv
Introduction.....	1
Culture.....	3
Environment of Care.....	6
Patient Safety	8
Recommendation 1.....	9
Recommendation 2.....	10
Integrated Veteran Care	12
Veteran-Centered Safety Net	14
Conclusion	18
Appendix A: Methodology	19
Appendix B: VISN Director Comments	21
Appendix C: Facility Director Comments	22
OIG Contact and Staff Acknowledgments	23
Report Distribution	24



Introduction

The Office of Inspector General (OIG), 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.⁶ VHA's vast care delivery structure requires sustained and thorough OIG oversight 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. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. 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. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:



Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.⁷



Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.⁸



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.⁹



Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.



Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.¹⁰

⁶ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁷ Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," *BMJ Open* 7, no. 11 (2017): 1–11, <https://doi.org/10.1136/bmjopen-2017-017708>.

⁸ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

⁹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The Togus VA Medical Center, part of the VA Maine Healthcare System (the facility), opened in 1866 and is the oldest VA hospital. Its site includes a national cemetery, where the final burial took place in 1961. In addition to the medical center in Augusta, the facility provides services at seven community-based outpatient clinics and two access clinics (designed to improve veterans' access to care by aligning capacity with patient demand) in Maine.¹¹ In fiscal year (FY) 2025, the facility had 59 hospital and 50 community living center beds, and it provided care to more than 44,000 veterans with a medical care budget of approximately \$760 million.¹²



Figure 1. Facility photo.

Source: “VA Maine Health Care,” VA, accessed March 24, 2026, <https://www.va.gov/maine-health-care>.

The OIG team inspected the facility from July 29 through 31, 2025, and contacted facility staff in January and July 2026 for updates. The executive leaders referred to throughout this report include the Medical Center Director (Director), Chief of Staff, Associate Director for Patient and Nursing Services, Associate Director for Healthcare Support Operations, and Associate Director for Ambulatory Care Operations. The most tenured executive leaders were the Director and Associate Director for Healthcare Support Operations, who had been in their positions since April 2019 and February 2022, respectively. The Associate Director for Patient and Nursing Services was appointed in January 2023. The Associate Director for Ambulatory Care Operations and the Chief of Staff were assigned in January and June 2025, respectively. At the time of the inspection, there was an Acting Chief of Staff while the permanent Chief of Staff was on leave.

¹¹ VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

¹² A community living center is also referred to as a VA nursing home. “Geriatrics and Extended Care,” VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 1) Togus VA Medical Center*, updated February 12, 2026.



CULTURE

The OIG team examined the facility’s culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization’s daily operations), and both employees’ and veterans’ experiences.¹³ The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).¹⁴ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁵

System Shocks

Executive leaders identified a mass casualty active shooter event in October 2023 as a significant system shock.¹⁶ The shooter attacked two separate locations near the facility’s community-based outpatient clinic in Lewiston. Law enforcement personnel were unable to locate the suspect for several days, which led to lockdowns across multiple towns and the clinic’s temporary closure. To ensure continued access to care during the closure, the Director reported that employees offered veterans virtual appointments or rescheduled them with providers at the medical center and other clinics.

The Associate Director for Ambulatory Care Operations emphasized that much of the state is a close-knit community, and the event’s effects extended well beyond Lewiston. In response to the event, leaders confirmed that all employees who worked or lived in the affected areas were accounted for and prepared to offer emergency medical care to people in the community. The leaders visited the Lewiston clinic when it reopened to support employees and connect them with resources such as counseling.

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

¹⁴ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁵ Patient advocates are employees who receive feedback from veterans and help resolve their concerns. “Patient Advocate,” VA, last updated May 9, 2022, <https://www.va.gov/HEALTH/patientadvocate>. For more information on the OIG’s data collection methods, see appendix A.

¹⁶ The Independent Commission, *Final Report of the Independent Commission to Investigate the Facts of the Tragedy in Lewiston*, August 20, 2024, <https://www.maine.gov/icl>.

Employee Experiences

Some OIG questionnaire respondents stated they remained at the facility because of their commitment to the mission of caring for veterans, job satisfaction, and connections with colleagues. However, others reported they considered leaving due to stress and burnout. Specific concerns included potential reductions in the workforce and a presidential memorandum that required federal workers to return to in-person work.¹⁷

Executive leaders acknowledged that recent national changes had created uncertainty among employees regarding job stability. The Director reported that leaders initiated a weekly all-employee call to address concerns and explain how the guidance may affect the facility. To support a positive work environment, a quality management specialist said the facility offers wellness and development programs, including leadership training.

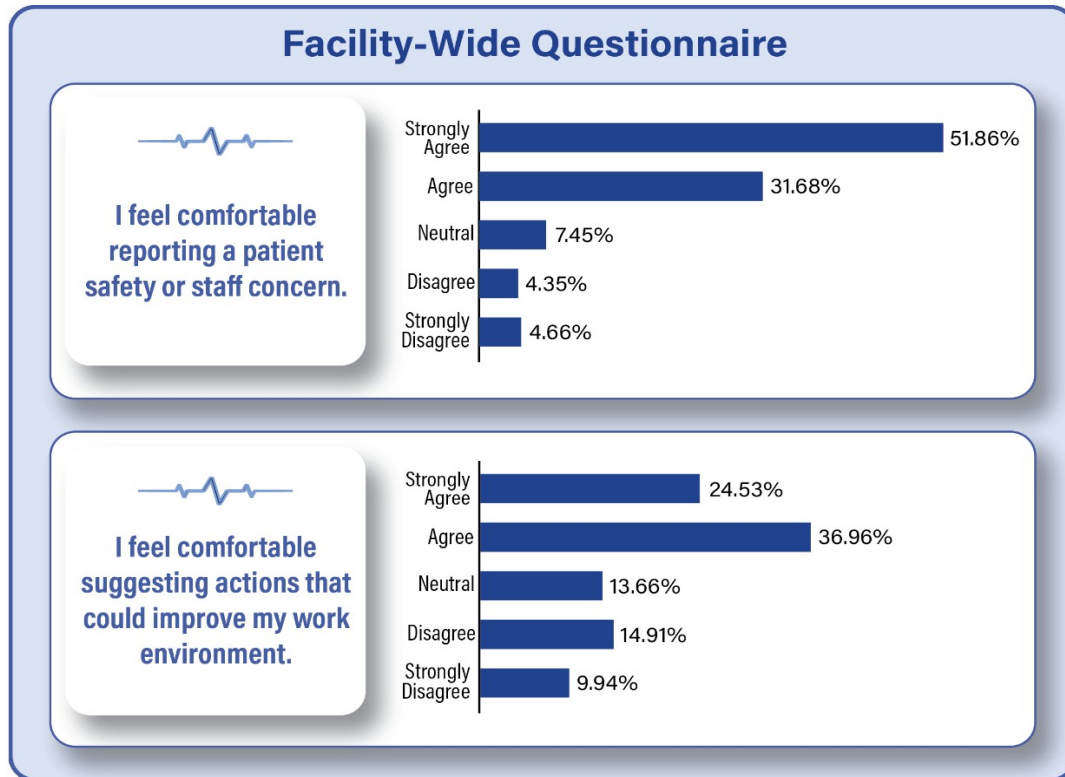


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

To enhance daily communication, the Director said leaders implemented tiered huddles (a series of meetings with employees and leaders at various levels) and a visual management system (informational displays about clinical and operational issues) throughout the facility in FY 2025. The Associate Director for Patient and Nursing Services also said leaders regularly attend

¹⁷ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

department meetings to increase their visibility, foster meaningful interactions with employees, and promote more frequent and transparent communication. Most OIG questionnaire respondents indicated that leader communications were clear, frequent, and useful. Employees' comfort with suggesting ways to improve their work or reporting concerns, as displayed in figure 2, also showed leaders' efforts were successful.

Veteran Experiences

In an OIG-administered questionnaire, patient advocates reported that veterans complete satisfaction surveys and contact them with concerns; both channels provide direct feedback to executive and service leaders, who are responsive to issues. One advocate said they work closely with employees in the Director's office to resolve complex problems.

The most common complaints reported by veterans involved the centralized call center, delays receiving test results, and turnover among primary care providers. Executive leaders explained that veterans could not directly contact their care teams through the Veterans Integrated Service Network (VISN) call center.¹⁸ In response, the Director said employees held outreach events to teach veterans how to use the My HealtheVet online portal to connect with their care teams.¹⁹

However, the Associate Director for Ambulatory Care Operations acknowledged ongoing delays in receiving test results from the National Teleradiology Program (which provides diagnostic radiology services) and community providers.²⁰ This concern is further addressed in the Integrated Veteran Care section.

¹⁸ Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, <https://www.va.gov/visns>. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>.

¹⁹ My HealtheVet is a secure website that allows VHA patients to access health records, manage appointments, refill prescriptions, and communicate with providers and staff. "Manage Your Health with My HealtheVet," VA, last updated June 12, 2026, <https://www.va.gov/health-care/manage-health>.

²⁰ VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.²¹ 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.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.²²

General Inspection

Signs clearly directed the OIG team to the main entrances and parking. The parking areas had ample lighting and were well maintained, with designated spots for veterans and employees, including accessible spaces for those with disabilities. Additionally, veterans can schedule rides through organizations such as Disabled American Veterans.

Inspectors observed emergency call boxes throughout the parking lots, which allow individuals to alert VA police for help. However, one light pole labeled "Police Call Box" did not have a call box. The chief of police shared plans to replace it; therefore, the OIG did not make a recommendation.

The main entrances had power-assisted sliding doors and a clearly marked passenger loading zone. The interiors were well lit and had seating and wheelchairs available. Volunteers in red

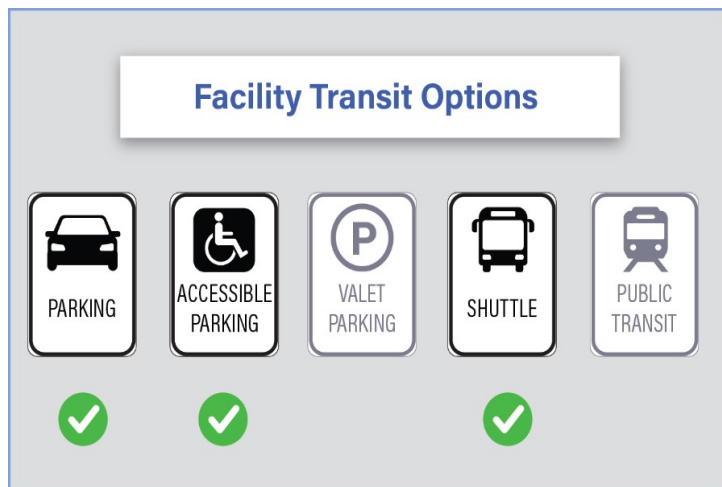


Figure 3. Transit options for arriving at the facility.

Source: OIG team observations, facility liaison questionnaire responses, and interview with facility staff and volunteers.

²¹ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²² VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *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.

vests were at an information desk located between the entrances of the emergency department and the pharmacy to provide directions or escort veterans to their appointments. Although printed maps were not available at the desk, a large map showed each building with its corresponding number, along with a directory of services. Directional signs and additional wall-mounted directories clearly guided veterans to clinical and nonclinical areas.

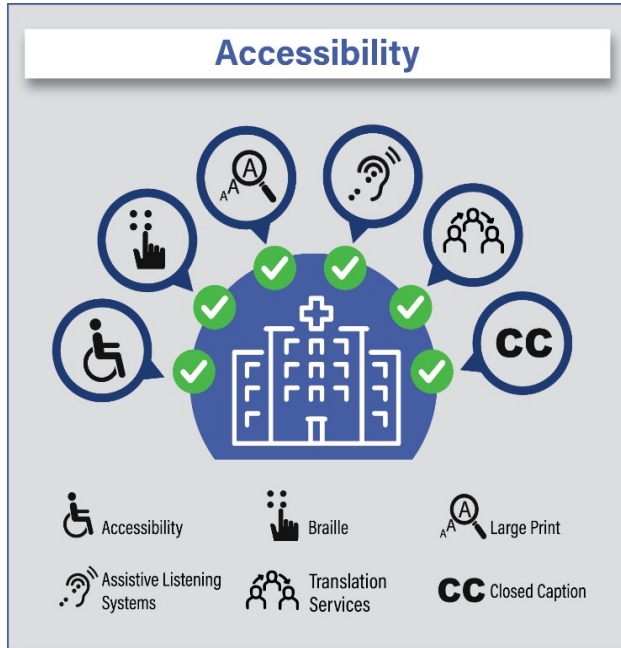


Figure 4. Accessibility tools available to veterans with impairments.

Source: OIG team observations, facility liaison's questionnaire response, and interview with facility staff.

The OIG team also observed braille signs and heard auditory cues to indicate the current floor in elevators. The acting chief veteran experience officer reported that staff can access resources for hearing-impaired veterans through the facility's website. Volunteers explained they receive training to assist veterans with hearing and visual impairments.

The team further inspected the following patient care areas: a medical-surgical unit (3North), intensive care unit (3East), primary care women's health clinic, primary care (Yellow Clinic), emergency department, and two parts of the community living center—Patriots Place (memory care) and Veterans Village (long-term care). The team noted white stains on ice machines in all inspected areas except for the primary care clinics, which did not have ice machines. The Joint Commission recommends paying “particular

attention to regularly scheduled cleaning, disinfection and maintenance to prevent build-up of water deposits, mold,” and other substances that can increase the risk of infection.²³

The acting chief of environmental management said the white stains are mineral deposits from the region's hard water and are difficult to remove, and staff were considering additional filtration to prevent the build-up. In February 2026, following the inspection in July 2025, facility staff reported that leaders inspected equipment during environment of care rounds and did not observe hard water stains from August 2025 to January 2026. Therefore, the OIG did not make a recommendation.

²³ “What Are the Maintenance Requirements for Ice Machines in Health Care Settings,” The Joint Commission, last updated April 21, 2026, <https://www.jointcommission.org/standards-faqs>.

The OIG also observed holes in walls and damaged floors, which were similar to findings from a 2023 OIG comprehensive healthcare inspection.²⁴ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, requires facilities to have a clean and safe environment.²⁵ At the time of the inspection in July 2025, leaders had not completed all corrective actions for the recommendation for the Director to keep patient areas safe and clean. The Associate Director for Healthcare Support Operations reported the loss of a staff member responsible for overseeing the action plan contributed to the problem. Staff submitted information in November 2025 that showed they had corrected the issues and the previous OIG recommendation was closed, so the OIG did not make a recommendation.

The Associate Director for Healthcare Support Operations and the safety officer stated that according to the supervisory healthcare engineer, there was an ongoing project to replace the floors, particularly in the main corridors. However, they explained that harsh environmental conditions and the facility's aging infrastructure complicated planning for permanent repairs. In July 2026, the healthcare engineer reported that the corridor floor replacement project is expected to begin in the spring of 2027 and be completed in the summer of 2028. Therefore, the OIG did not make a recommendation.



PATIENT SAFETY

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical abnormal test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The OIG reviewed the facility's test result communication policy and determined it did not describe the process of assigning a designee to receive test results when a provider no longer worked at the facility, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.²⁶ In addition, the Acting Chief of Staff and Associate Director for Patient and Nursing Services had not developed service-level workflows that outline responsibilities in the patient notification process for all types of test results, which is also required by the directive. The OIG reviewed updated information provided by the accreditation coordinator in July 2026 and determined leaders had not corrected these findings.

²⁴ VA OIG, [Comprehensive Healthcare Inspection of the VA Maine Healthcare System in Augusta](#), Report No. 23-00109-121, April 3, 2024.

²⁵ VHA Directive 1608(1).

²⁶ VHA Directive 1088(1).

Recommendation 1

The Chief of Staff and Associate Director for Patient and Nursing Services develop service-level workflows that outline responsibilities in the patient notification process and update the facility's test result communication policy to align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

Target date for completion: December 31, 2026

Director Comments

Quality Management (QM) reviewed VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* (dated July 11, 2023; amended September 20, 2024), alongside VA Maine Medical Center Policy MCP 00-25-35, *Communicating Test Results to Providers and Patients* (dated July 1, 2025). A gap analysis was conducted to identify whether revisions were needed to bring the local policy into full compliance with VHA Directive 1088(1).

Following the review, it was determined that the local policy required additional service-level workflows that clearly define provider and staff responsibilities, along with more detailed procedures for communicating test results to both ordering providers and patients.

A revised, compliant policy is being drafted by the QM staff to address these gaps and will then be approved through the local governance structure. Final publication is anticipated by December 31, 2026.

The systems redesign coordinator, who reported leading improvement efforts at the facility, presented quarterly External Peer Review Program data, which includes information about providers' communication of test results, to the Quality and Patient Safety Committee.²⁷ The OIG reviewed the committee minutes, which showed that providers communicated abnormal test results to patients that required action within seven days of receiving the results, as required by VHA Directive 1088(1), 46–77 percent of the time.

VHA Directive 1088(1) also requires the chief of staff and associate director for patient care services to review test result communication data and implement corrective actions for identified deficiencies. However, after learning about issues with providers communicating test results during committee meetings, the Acting Chief of Staff and Associate Director for Patient and

²⁷ The External Peer Review Program is a system process that supports “review of identified medical records to assess the quality of both inpatient and outpatient care” at VHA facilities. VA, *External Peer Review Program (EPRP)*, March 15, 2022.

Nursing Services did not develop improvement actions. When leaders do not implement actions to improve the communication of test results, patients may experience delays in diagnosis and treatment.

Recommendation 2

The Chief of Staff and Associate Director for Patient and Nursing Services implement actions based on external peer review data to improve providers' communication of test results to patients, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

Target date for completion: December 31, 2026

Director Comments

VA Maine has implemented actions based on External Peer Review Program (EPRP) data to improve providers' communication of test results to patients, in accordance with VHA Directive 1088(1).

Real-Time Chart Review Process

VA Maine Quality Management staff have initiated real-time reviews of the chart samples pulled for EPRP review. These real-time audits have identified compliant records that were forwarded to EPRP for reconsideration, resulting in corrections by the data abstractor.

Clinisys Implementation

VA Maine has implemented Clinisys, a software program that automates delivery of test results to patients. Clinisys was originally rolled out to the Primary Care clinics at VA Maine.

Data review of EPRP fallouts identified two services with recurring fallouts. VA Maine has since implemented Clinisys to these two locations to improve the timeliness of results communication.

Provider Education

Education was completed by the Chief of Staff at the Medical Dental staff meeting regarding the expectation of timely test result communications.

EPRP Performance Measures

Two EPRP measures track communication of test results to patients:

- **CTR24** – Communication of Abnormal Test Results: reviews whether abnormal test results requiring action are communicated in compliance with directive requirements.
- **CTR25** – Communication of Abnormal Test Results within 30 Days: reviews whether abnormal test results requiring action are communicated to the patient within 30 days of the test report.

Current Compliance Status

Per the most recent EPRP exit report dated August 5, 2026, VA Maine achieved a compliance rate of **93.3%** for CTR24 and **100%** for CTR25.

Ongoing Monitoring

VA Maine will continue to report CTR24 and CTR25 compliance rates to the Quality, Patient Safety, and Value Council (QPSC) on a quarterly basis to ensure sustained compliance. VA Maine will request closure once two quarters of the CTR24 and CTR25 are greater than 90% compliant.

Action Plans and Process Improvements

When asked how the facility manages oversight findings and recommendations, the accreditation coordinator explained that quality management staff collaborate with program staff to develop action plans. The OIG reviewed patient safety reports from the 12 months preceding the July 2025 inspection and identified trends involving laboratory and pathology processes, primarily related to improper specimen labeling. The patient safety manager reported that there were no adverse patient safety events related to the issue, and in response to the trends, laboratory staff had educated service staff on how to accurately label specimens.

The acting chief of quality management noted that most process improvement projects originate from patient safety and leadership rounding (spending time in work areas to speak with employees). For example, one performance improvement project addressed staff concerns about delays in repairing broken equipment. The project identified gaps, including limited staff awareness of how to submit work orders.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.²⁸ The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Facility primary care leaders provided the OIG team with data that showed 14 provider positions, along with vacancies for 1 registered nurse, 3 licensed practical nurses, and 4 medical support assistants at the time of the inspection in July 2025. Primary care leaders attributed provider vacancies to retirements, recruitment challenges associated with the facility's rural location and lower pay compared to nearby facilities, and resignations related to workload expectations. The patient centered management module coordinator also reported that a cumbersome hiring process delayed onboarding and led some candidates to decline offers.

A primary care leader explained that to maintain patient access to care, they used providers from the VISN Clinical Resource Hub (which provides healthcare services when local facilities do not have the capabilities) and fee-basis providers (who receive compensation based on work performed).²⁹ The leader added that fee-basis providers at the facility are not assigned as primary care providers in the patient's electronic health record, so they are unable to manage or respond to electronic alerts in the system; facility providers must perform these tasks. The leader said this workflow causes continuity of care concerns, risk of delays following up on critical alerts, and administrative burdens for the staff providers.

According to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, the baseline capacity for panel size (number of patients assigned to a care team) is 1,200 patients.³⁰ Primary care leaders and the patient centered management module coordinator explained that some panels were below capacity. The coordinator said that to address staffing gaps, clinics implemented strategic coverage plans. For example, the Bangor clinic divided a patient panel among several providers until a new provider could be hired.

²⁸ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

²⁹ "Clinical Resource Hubs (CRH)," VA, accessed June 30, 2026, <https://www.patientcare.va.gov/CRH>.

³⁰ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

However, new patient appointment wait times in FY 2025 averaged around 40 days in quarter one and 57 days in quarter two, which under the Code of Federal Regulations (title 38, section 17.4040) meant patients met the wait time eligibility of 20 days for referral for community care.³¹ The Director told the OIG that patients were offered referrals to the community for primary care. Although vacancies, workload imbalances, and extended wait times continued to affect access to care, leaders were actively working to resolve the issues, so the OIG did not make a recommendation.

Community Care Staffing and Access to Care

In an OIG-administered questionnaire, community care staff identified inadequate staffing and excessive workload as their primary concerns, and community care leaders agreed. The community care program faced recruitment and retention challenges; leaders explained that some staff either retired or resigned rather than returned to the office. To address vacancies, the acting chief of integrated veteran care said staff began training nurses from other departments to help coordinate referrals. Additionally, the acting chief said executive leaders recently approved hiring three nurses.

Leaders reported that patient care has increasingly shifted to the community after the loss of several specialty care providers at the facility. Further, patients at the Presque Isle community-based outpatient clinic met drive-time eligibility for specialty community care due to its location, which is four hours from the facility.

Community care leaders also reported that workload increases when community providers request additional appointments beyond what was previously authorized. The acting chief of integrated veteran care said staff review each request to ensure veterans receive appropriate, high-quality care before approving additional visits.

The OIG found the facility's top three community care services—chiropractic, dental care, and physical therapy—had average scheduling times of 27, 13, and 27 days, respectively, exceeding the requirement of 7 days stated in VHA's *Consult Timeliness Standard Operating Procedure*.³² Community care leaders said scheduling delays often occurred when facility referrals were incomplete or lacked required information, such as imaging or laboratory results. To improve the process, community care staff now educate primary care staff on how to properly submit a community care referral during new employee orientation. They also embedded commonly used forms into the VA referral template to ensure staff document all required information.

Leaders also cited limited access to community providers as a major contributor to delays. They expressed concern that veterans experience long wait times—sometimes up to 18 months—for

³¹ 38 C.F.R. § 17.4040 (2025).

³² VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated October 2, 2025.

some specialty care; additionally, many community providers did not accept new patients.³³ Leaders attributed these challenges to the rural setting and recent local hospital closures that reduced available community providers and explained there is a process for referrals that need to be expedited.

Finally, leaders described difficulties obtaining clinical records from community providers. While many providers use an online database that staff can easily access to obtain records, staff must reach out to many community providers repeatedly. To save time, leaders said staff often contact patients first to confirm their visit before requesting records.



VETERAN-CENTERED SAFETY NET

The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), 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 facility 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.³⁴

During this inspection, VHA used three performance measures to determine the success of each facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.³⁵ 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 (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional

³³ VA, "Community Care Network (CCN)" (fact sheet), January 21, 2022.

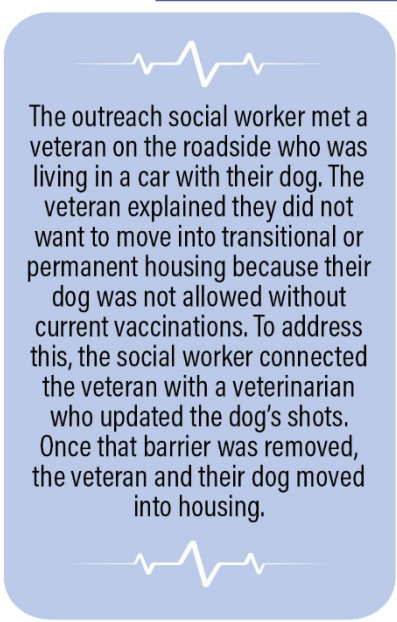
³⁴ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

³⁵ VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

residences for veterans with mental health or substance use conditions).³⁶ Finally, HCHV2 measured the percentage of veterans who are discharged from the program’s contracted emergency residential services or low-demand safe haven beds due to a “violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits).”³⁷

Performance and Improvement Highlights

- The facility’s program did not meet the intake assessment (HCHV5) target in the first two quarters of FY 2025. Despite missing the target, the outreach social worker described strong connections with community partners like veterans organizations, state and local governments, and police departments, who refer veterans to the program. The program coordinator also discussed an upcoming surge event where facility program staff and community partners work together to identify unsheltered veterans and connect them to VA resources.
- Although the facility missed the exit to permanent housing (HCHV1) target for FY 2024, it met the target in the first two quarters of FY 2025. The coordinator explained that the team did not meet the FY 2024 target partly because some veterans could not live independently but declined placement in an assisted-living facility; others were reluctant to meet with primary care providers for the required referral. To address this, program staff met with facility primary care and geriatric extended care providers to secure appropriate placement for veterans who cannot live alone.



The outreach social worker met a veteran on the roadside who was living in a car with their dog. The veteran explained they did not want to move into transitional or permanent housing because their dog was not allowed without current vaccinations. To address this, the social worker connected the veteran with a veterinarian who updated the dog's shots. Once that barrier was removed, the veteran and their dog moved into housing.

Figure 5. Best practice for veteran engagement.

Source: OIG interview with HCHV staff.

³⁶ VHA sets targets for HCHV1 at the national level each year. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

³⁷ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

- The outreach social worker also discussed the Boothbay Veterans Emergency Temporary Shelter (VETS) Trailers, a local organization that retrofits trailers with a bed, microwave, and heater to provide temporary shelter.
- The facility met the target for negative exits (HCHV2) in the first two quarters of FY 2025. The social worker said ongoing communication with community partners to address concerns early and clarify program expectations helped keep these exit numbers low.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including “serious mental illness, physical health diagnoses, and substance use disorders.”³⁸ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³⁹

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).⁴⁰

Performance and Improvement Highlights

- At the time of the OIG team’s visit in July 2025, the facility’s program had not yet met the target for voucher use (HMLS3) for FY 2025. The HUD-VASH program manager explained that facility staff issued all 248 vouchers, but limited affordable housing is a significant challenge for veterans in using them. Additionally, landlords deny applications because of criminal history, poor credit, or bad references.
- To help reduce these barriers, staff participate in the Maine Homeless Veterans Action Committee and collaborate with housing agency personnel during landlord engagement events across the service area.⁴¹ During the events, program staff explain how the voucher program works and how they continue to work with

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

³⁹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁰ VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility’s program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measure*.

⁴¹ “Committees,” Maine Homeless Planning, accessed June 30, 2026, <https://www.mainehomelessplanning.org>.

veterans and landlords once the veteran is permanently housed. Current landlords attend to share their experience and explain the benefits of renting to veterans.

- Program staff also told the inspectors that the Lewiston Housing Authority has started looking for landlords who are willing to accept project-based vouchers that are tied to specific apartments, not to the veterans who live in them (if a veteran moves out, the voucher stays with the unit and can be used by another eligible veteran). Project-based vouchers help keep apartments occupied and strengthen local housing stability.
- The program met the employment (VASH3) target in the first quarter of FY 2025. The homeless program manager explained that when veterans seeking employment enroll, the program's employment specialist helps them find a job. The employment specialist is also a member of the Maine Homeless Veterans Action Committee, where community partners also share employment resources.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.⁴² Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).⁴³

Performance and Improvement Highlights

- The facility's program did not meet the enrollment measure in the first two quarters of FY 2025. The homeless program coordinator stated that vacant positions had left two of three staff members to cover the state's courts, jails, and prisons.
- In the OIG questionnaire, a veteran justice outreach specialist also identified difficulties accessing jails and the state's rural location as barriers to enrolling veterans into the program. Facility program staff reported they conduct outreach with community partners through regular meetings—virtual and in-person—and other events.

⁴² VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴³ VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Conclusion

To assist leaders in evaluating the quality of care at the VA Maine Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the communication of test results. 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, OIG 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.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from July 29 through 31, 2025, and contacted facility staff in January and July 2026 to obtain updated information. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.⁴⁴ During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust*.⁴⁵

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁴⁶ The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

⁴⁴ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁴⁵ Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

⁴⁶ 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>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁴⁷ The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

⁴⁷ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 23, 2026

From: Director, VA North Atlantic Health Network (10N1)

Subj: Healthcare Facility Inspection of the VA Maine Healthcare System in Augusta

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report regarding the healthcare inspection report at the VA Maine Healthcare System. The VA North Atlantic Health Network is committed to providing exceptional healthcare to Veterans.
2. I thank the OIG team for their recommendations which identify areas for improvement.
3. The leadership teams at VA Maine 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 S. Lilly, MPA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 22, 2026

From: Director, VA Maine Healthcare System (402)

Subj: Healthcare Facility Inspection of the VA Maine Healthcare System in Augusta

To: Director, VA North Atlantic Health Network (10N1)

1. I have reviewed the draft report, Healthcare Facility Inspection of the VA Maine Healthcare System in Augusta, Maine. I concur with the findings and recommendations.
2. I have reviewed and concur with the submitted action plans for the healthcare system.
3. I would like to thank the OIG Inspection Team for a comprehensive review of the VA Maine Healthcare system.

(Original signed by:)

Tracye B. Davis, FACHE
Medical Center Director, VA Maine HCS

OIG Contact and Staff Acknowledgments

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