US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Connecticut Healthcare System in West Haven

Healthcare Facility Inspection	24-00610-164	July 9, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Connecticut Healthcare System (facility) from July 23 through 25, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Facility leaders identified system shocks as infrastructure challenges that led to the deaths of a staff member and contractor, a patient's death during a construction project, and turnover in leadership positions.

The acting Associate Director of Patient Care and Nursing Services told the OIG that one of the biggest system shocks was infrastructure challenges, which included a steam explosion that caused the death of an employee and contractor in 2020. Leaders also discussed a patient's death during a disruption to the oxygen main line in 2022. Other infrastructure breakdowns included heating and cooling problems and flooding from ruptured pipes. In response, leaders addressed the environmental concerns and improved communication about actions taken to address the problems.

Leaders also discussed key leadership turnover within the past three years and said it had delayed operations decisions, such as renewing a contract intended to resolve temperature issues

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

throughout the facility. Although leaders were working to reinstate the contract, the OIG noted temperature differences throughout the facility during the physical inspection, and leaders said they provided staff with fans or allowed them to work in another area.

Regarding employee experiences, VA All Employee Survey best places to work scores declined from fiscal years 2021 to 2022 but increased in fiscal year 2023.[2] Respondents to the OIG's questionnaire indicated they would consider leaving the facility due to stress and burnout. Although leaders attributed stress and burnout to working in health care and the COVID-19 pandemic, the Chief Wellbeing Officer facilitated retreats for employees and educated supervisors on methods to support them.

For veterans' experiences at the facility, the OIG's questionnaires indicated most patient advocates and veteran service organization respondents feel facility leaders are responsive to veterans' concerns.[3] However, patient advocates indicated leaders have not effectively addressed the most frequently reported issue, which was unanswered phone calls. The Director described dealing with the issue by reviewing options for a voicemail or virtual phone queue system. Leaders also said they encouraged veterans to contact their care team via secure messaging. The OIG recommends leaders address the issue of unanswered calls.

Environment of Care

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

The facility had ample parking and a new parking garage under construction. The OIG observed clear navigational signs outside and inside of the facility, and volunteers at the information desk available to help veterans get to their destinations. The OIG also noted sign language interpretation services, assistive listening devices, and braille throughout the facility to assist veterans with sensory impairments.

The OIG evaluated the facility's ability to assist veterans with toxic substance exposures under the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive

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

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

Toxics (PACT) Act.[4] The OIG found 1,439, or 3 percent of secondary (follow-up) screenings had not been completed within 30 days, per VHA's recommendation. Because leaders had staff identify veterans who were overdue for screening and educated providers on the importance of completing them, the OIG did not make a recommendation.

The OIG discovered the facility did not meet two of VHA's fiscal year 2023 performance targets: senior leaders attend environment of care rounds at least 90 percent of the time, and staff close deficiencies or create an action plan to address them within 14 days. However, leaders attended all rounds for fiscal year 2024, and staff developed an action plan to improve performance.

The facility also did not meet a third performance target in fiscal year 2023 for staff identifying environment of care trends and establishing performance improvement plans to address them. Since performance had not improved in fiscal year 2024, the OIG recommends staff address this deficiency.

The OIG also found beds and a stretcher in patient care areas did not have preventive maintenance, as required. Although the Assistant Chief of Facilities Management Service explained the manufacturer performs the maintenance, the OIG only found maintenance documentation for one bed and therefore recommends leaders hold the manufacturer to contractual requirements to perform preventive maintenance.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined facility leaders had a process to communicate urgent, noncritical test results to providers and patients that was compliant with VHA's updated directive.[5]

Leaders have various methods to identify opportunities for process improvements. For example, the Patient Safety Manager tracks patient events, the Risk Manager evaluates quality indicators related to the peer review process, and the Chief of Primary Care formally evaluates clinicians using clinic notes.[6] The Patient Safety Manager and Risk Manager share lessons with each other

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

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

[6] A peer review "is a critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

and with facility and Veterans Integrated Service Network leaders.[7] The OIG did not identify barriers to implementing action plans or monitoring improvements.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the PACT Act affected the primary care delivery structure and new patient appointment wait times.

Primary care leaders reported approximately 20 vacancies for registered nurses, licensed practical nurses, and medical support assistants. The leaders described recruitment challenges, including higher wages for licensed practical nurses in the private sector. To minimize the effect of the vacancies on patient care, leaders said they had staff from the Clinical Resource Hub cover vacant positions.[8]

The OIG also noted veteran enrollment had decreased slightly over the three years prior to the inspection, which leaders attributed to people leaving the area due to cold weather and a higher cost of living as compared with other places. Primary care leaders reported there were no changes in primary care team efficiency, and appointment wait times for new and established patients remained stable since the PACT Act's implementation.

Primary care leaders and staff said the Veterans Integrated Service Network call center contributed to workflow inefficiencies, increased workload, and possibly risked patient safety. Primary care leaders shared an example in which call center staff directed veterans who requested medication refills to the pharmacy when the medications could have been mailed and eliminated the need for an in-person visit. The OIG determined primary care leaders were aware of the issue but had not resolved it at the time of the inspection. The OIG recommends the Veterans Integrated Service Network Director work with facility and primary care leaders to address concerns with the call center.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG

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

[8] Clinical Resource Hubs allow veterans to receive care at their local facilities from providers at another location through telehealth technology. "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed May 22, 2024, https://www.patientcare.va.gov/primarycare/CRH.asp. Virtual clinics are a way to meet with the primary care team without traveling to the office. "VA Telehealth," Department of Veterans Affairs, accessed December 18, 2024, https://telehealth.va.gov/type/home.

found program staff enroll veterans in the programs and coordinate care by referring them to community partners and community residential and facility programs to address their needs. The OIG evaluated specific program metrics to determine how well programs were meeting veterans' needs.

Program staff did not meet performance targets for completing intake assessments for homeless veterans in fiscal years 2021 through 2023. Staff said they failed to document all intake assessments. Therefore, leaders educated them on documentation standards to ensure more accurate records going forward. Program staff also did not meet targets for discharging veterans to permanent housing or minimizing veterans exiting the program for not complying with requirements or before consulting with staff. Staff stated veterans left the program because they did not want to live in temporary shelters while waiting for permanent housing. Although this remained a challenge, the director met regularly with veterans and staff to improve engagement.

Housing and Urban Development–Veterans Affairs Supportive Housing program staff did not meet targets for using housing vouchers from fiscal years 2021 to 2023. Program staff identified difficulties in meeting veterans' housing needs due to low housing availability and high rental costs; the closing of some housing authorities; reduced community program services during the pandemic; and veterans' low credit scores, legal issues, and eviction histories. To address these barriers, staff worked with a community partner to offer incentives to landlords who were willing to rent to veterans. Although program staff did not meet it for fiscal year 2023, they did meet veteran employment targets for fiscal year 2022. Staff said incorrect data entry contributed to missing the target in fiscal year 2023.

Although the facility did not meet most program targets, the OIG did not make recommendations because program leaders had taken actions to resolve the barriers, and program staff were working within their resources to address the needs of the veterans.

What the OIG Recommended

The OIG made four recommendations.

1. Facility leaders develop and implement a plan to address veterans' unanswered phone calls.
2. The Associate Director ensures staff identify environment of care trends and establish performance improvement plans with outcome measures to address them.
3. The Associate Director ensures the manufacturer satisfies contractual requirements to perform preventive maintenance for beds and stretchers and documents the service.
4. The Veterans Integrated Service Network Director works with facility and primary care leaders to address the network call center's effect on primary care team efficiency and workload and reduce the risk of adverse patient safety events.

VA Comments and OIG Response

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

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

Abbreviations

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

FACILITY IN CONTEXT

VA Connecticut Healthcare System
West Haven, Connecticut
Level 1a-High Complexity
New Haven County
Hospital Referral Region: New Haven

Description of Community

POPULATION

Female **3,131,675**	Male **2,990,091**
Veteran Female **18,616**	Veteran Male **218,827**

Homeless - State **2,930**
Homeless Veteran -State **149**

MEDIAN INCOME

$84,741

EDUCATION

91% Completed High School
70% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **212**

SUBSTANCE USE

26.4% Driving Deaths Involving Alcohol
20.7% Excessive Drinking
2,251 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	2,232,786
Carpool	238,067
Public Transportation	233,627
Work at Home	222,968
Walk to Work	77,414
Other Means	42,095

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**15.5 Minutes, 10 Miles**
Specialty Care	**30.5 Minutes, 22.5 Miles**
Tertiary Care	**51.5 Minutes, 45.5 Miles**

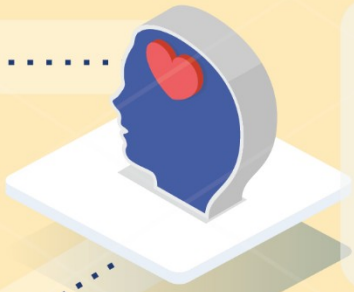
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **18,577**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	34%
<65 without Health Insurance	9%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

16,835

117 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.27 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
14	21

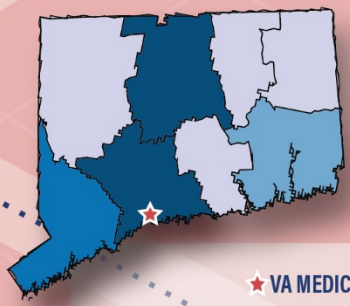
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	60K
Unique Patients VA Care	58K
Unique Patients Non-VA Care	15K

COMMUNITY CARE COSTS

Unique Patient $49,416	Outpatient Visit $386
Line Item $3,667	Bed Day of Care $390



STAFF RETENTION

Onboard Employees Stay <1 Yr	6.56%
Facility Total Loss Rate	9.49%
Facility Retire Rate	2.93%
Facility Quit Rate	5.77%
Facility Termination Rate	0.79%

★ VA MEDICAL CENTER

VETERAN POPULATION

4.62% 8.45% 12.28% 16.11% 19.94% 23.71%

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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

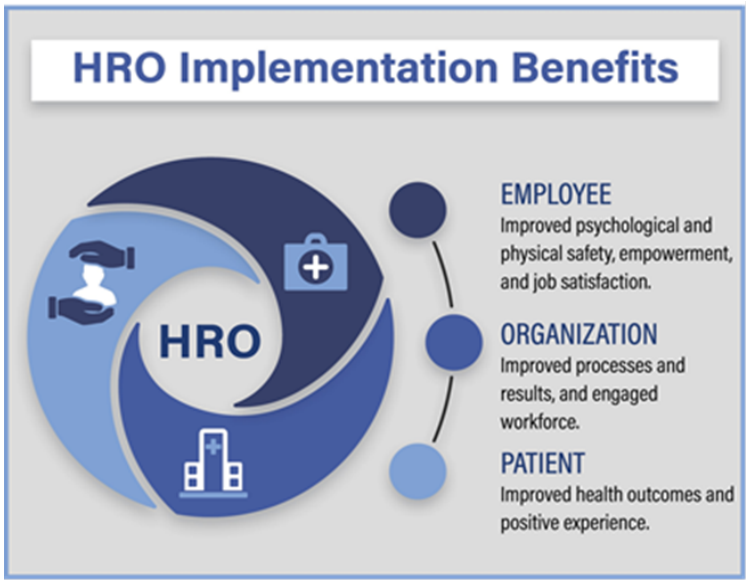


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

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

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

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

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

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

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

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

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

operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

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

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

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

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

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

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

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

The West Haven site of the VA Connecticut Healthcare System (facility) was opened in 1953. At the time of the inspection, the facility's executive leaders consisted of the Executive Director (Director), interim Deputy Executive Director, Chief of Staff, acting Associate Director of Patient Care and Nursing Services, and Associate Director. The Director was assigned in October 2023, the Chief of Staff had been in place since June 2021, and the Associate Director had served in the role since 2012. The facility had 182 operating beds (129 hospital, 25 community living center, and 28 domiciliary beds) and a fiscal year (FY) 2023 medical care budget of over $950 million.[13]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_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, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp.

[14] 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.

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18]

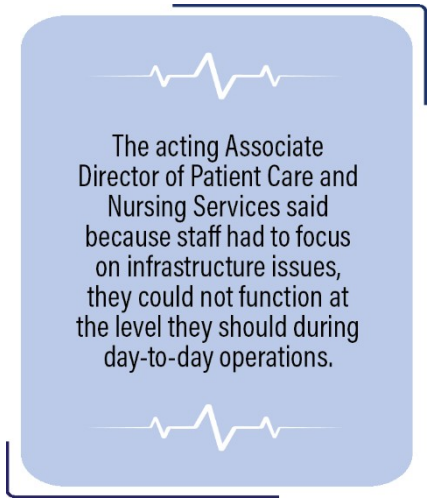


Figure 4. *Leader's comment about a system shock.*
Source: OIG interview.

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In interviews, facility leaders described significant system shocks as infrastructure issues that led to the death of a contractor and employee, a patient death that occurred during a disruption to the oxygen main line, and turnover in leadership positions.

The acting Associate Director of Patient Care and Nursing Services told the OIG the biggest system shock was infrastructure breakdowns. Leaders described how a steam explosion had caused the death of a contractor and an employee in late 2020. Since then, multiple infrastructure incidents had occurred, including a flood after a water pipe burst in the computed tomography scanning area in 2023.

The acting Associate Director of Patient Care and Nursing Services said the infrastructure disruptions affected day-to-day operations, causing employees to respond to the problems rather than carry out their primary roles. Further, staff found it difficult to depend on the infrastructure when it repeatedly failed. For example, a contract intended to resolve temperature issues had lapsed, leaving heating and cooling issues throughout the facility. At the time of the inspection, leaders were working to reinstate the contract, and in the interim, providing staff with fans and options to work in areas with consistent temperatures.

An additional system shock occurred in 2022 when a construction project disrupted the main oxygen line. When the OIG report of the incident was published more than a year later, it

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

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

brought renewed attention to the event, causing staff to feel the effect of the incident once again.[19]

Leaders also expressed that turnover in key leadership positions occurred within the last three years and delayed decisions regarding operations. According to the Director, there was a tendency for acting leaders to delay actions when a new permanent director was scheduled to start. For example, acting leaders would address environmental issues, such as with heating and cooling, with a temporary fix while waiting for the appointment of a permanently assigned director, who would implement a long-term solution. The Director said that soon after arriving to the facility, staff expressed the need for leaders to stay long enough to enact change.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23] The survey indicated staff's perceptions of leaders' communication had remained stable between FYs 2021 and 2023. The OIG questionnaire showed most respondents perceive leaders' communication as frequent, clear, and improved over previous efforts.[24]

Leaders emphasized the importance of explaining decisions, being open to suggestions, and acknowledging errors in communicating with staff. The Director shared an example of leaders' miscommunication regarding blocked roads leading to staff parking, resulting in them arriving late to work. Staff provided feedback to leaders about the miscommunication, and in response,

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[19] VA OIG, *Facility Leaders' Failure in Communications, Construction Oversight, Emergency Preparedness, and Response to an Oxygen Disruption at the West Haven VA Medical Center in Connecticut*, Report No. 22-01696-160, July 27, 2023.

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

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

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

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

[24] The VA Connecticut Healthcare System had 3,531 employees and 353 of them responded to the questionnaire.

leaders apologized and implemented changes. One change provided staff the opportunity to sign up for notifications on personal devices about situations that could affect their commutes. Leaders also shared various avenues used to communicate with staff, such as emails, visits in their work areas, and service chiefs' attendance at leadership meetings in which they relay information during their staff meetings.

Employee Experience

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

The OIG noted that All Employee Survey scores for the best places to work decreased from FYs 2021 to 2022 but increased in FY 2023.[27] Leaders attributed the lower FY 2022 score to the lack of permanent leaders that year.

Figure 5. *The Chief of Staff's comment about the All Employee Survey scores. Source: OIG interview.*

Respondents to the OIG questionnaire cited stress and burnout as the primary reasons they would consider leaving the facility. Facility leaders stated stress and burnout were inherent to working in health care, and suggested some employees were still recovering from the COVID-19 pandemic. The OIG learned through interviews the Chief Wellbeing Officer facilitated retreats for employees and trained supervisors on ways to support those experiencing burnout, such as recognizing different responses to stress and increasing supervisors' emotional intelligence.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The VA survey scores for psychological safety had increased over the past three years. The OIG questionnaire showed most respondents feel comfortable reporting

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

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

[27] Best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

concerns. During interviews, the OIG found that leaders are committed to improving employees' experiences. The Director shared an example of working alongside nonsupervisory employees, at their request, to engage with them and learn their job duties.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In response to OIG questionnaires, most patient advocates and VSOs conveyed that facility leaders are generally responsive to veterans' concerns. The advocates indicated that veterans' most frequent complaint is unanswered phone calls, and a VSO respondent reported a lack of direct phone communication with the healthcare team.

During interviews, the Director said leaders addressed veterans' concerns by assigning staff to answer the phones and reviewing options for veterans to leave a voicemail or wait in a virtual line on the phone. To address the lack of direct phone communication with care teams, leaders said they encouraged veterans to use other available options, such as secure messaging, to reach their team. The OIG recommends facility leaders develop and implement a plan to address veterans' unanswered phone calls.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[30] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 6. *Facility photo.*
Source: "VA Connecticut Health Care," Department of Veterans Affairs, accessed August 6, 2024, https://www.va.gov/connecticut-health-care/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[31] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[32]

[30] VHA Directive 1608(1).

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

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

Transit and Parking

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

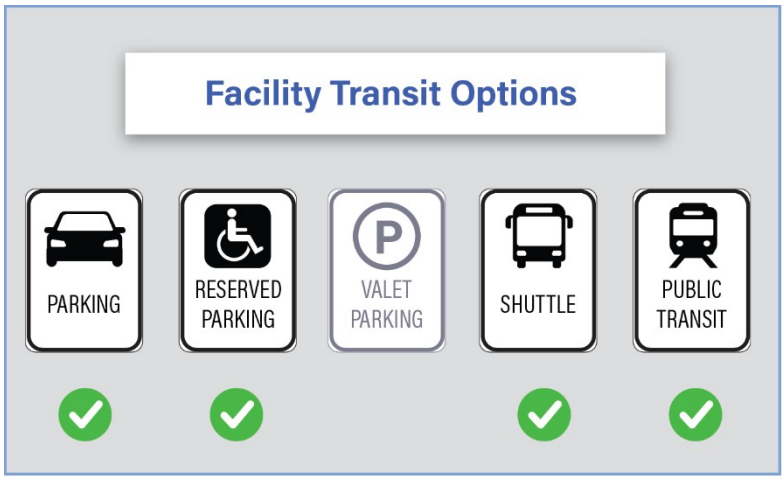

Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of questionnaire responses, documents, and an interview.

The OIG used the navigation link on the facility's website to successfully reach the main entrance, then easily located a parking lot using posted signs; the lot had ample parking availability at the time the team arrived. According to the facility liaison, veterans could reach the facility via public buses, train, shuttle, or taxi services.

The OIG observed a parking garage under construction, which leaders said would be completed in January 2025. The Assistant Chief of Facilities Management Service said leaders expanded shuttle service for off-site parking areas during the construction and added more signs and pedestrian paths to improve navigation to the main entrance.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[33]

The OIG easily found the main entrance using signs posted on the building. The main entrance was covered by an overhang and had a patient loading zone. The OIG entered the building through power-assisted sliding doors and found the interior clean and well-lit, with seating options and available wheelchairs.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined

[33] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[34]

The OIG observed staff and volunteers at the information desk inside the main entrance assisting veterans with directions and escorting them to various locations. Although the information desk did not have maps available, staff said they were developing printed and digital maps. The OIG also noted a large campus map showing each building with its corresponding number, along with a directory of services and their building locations. The OIG easily found locations throughout the facility.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[35] The facility liaison highlighted sign language interpretation services, assistive listening devices, and closed captioning capability on televisions for veterans with hearing impairments. The liaison added that staff and volunteers are trained to assist visually impaired veterans. During the physical inspection, the OIG observed signs with braille characters at elevators and throughout the facility.

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents.

Toxic Exposure Screening Navigators

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

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

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

based on VA's guidelines.[36] The OIG learned from a questionnaire that the facility had two toxic exposure screening navigators; both were assigned the responsibility as a collateral (additional) duty. One navigator indicated that staff screened most veterans during primary care visits. While on-site, the OIG noted the facility had handouts available for veterans in the Emergency Department and primary care settings.

The OIG reviewed facility data and found staff had not completed 1,439, or 3 percent, of secondary (follow-up) screenings within VHA's recommended time frame of 30 days. Delays in these screenings could affect early detection and treatment of conditions related to toxic exposure.

Primary care leaders explained that when VHA implemented the toxic exposure screening process, there was no secondary screening requirement. However, when VHA added it, leaders had staff review all primary screenings to determine who needed the second screening. Leaders also educated providers on the importance of these screenings in identifying health conditions related to toxic exposure. Since leaders had addressed the issue, the OIG did not make a recommendation.

Repeat Findings

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

The OIG reviewed environment of care reports and found the facility did not meet VHA's FY 2023 performance targets for

- senior leaders attending environment of care rounds at least 90 percent of the time,
- staff closing at least 90 percent of environment of care deficiencies or creating an action plan to address them within 14 business days, and

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

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

- staff identifying one or more environment of care trends and submitting performance improvement plans with outcome measures to the Associate Director.[38]

In an interview, the Associate Director acknowledged the deficiencies and attributed them to having several interim associate directors to oversee safety and difficulties in recruiting a permanent Chief of Safety. The facility liaison provided the OIG with documentation showing senior leaders' attendance at environment of care rounds had improved to 100 percent for the first three quarters of FY 2024; and although staff did not close deficiencies within 14 days, they provided an action plan to the OIG outlining improvements. Therefore, the OIG did not make a recommendation.

However, since staff had not improved performance for identifying environment of care trends and submitting performance improvement plans to the Associate Director in FY 2024, the OIG recommends the Associate Director ensures staff identify environment of care trends and establish performance improvement plans with outcome measures to address them.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy. The OIG inspected multiple patient care areas while on-site. The OIG found the areas clean, with clear pathways and no privacy concerns.

However, the OIG found multiple beds and a stretcher in patient care areas without evidence of required preventive maintenance. The Assistant Chief of Facilities Management Service explained the facility has a contract with the manufacturer to maintain the equipment. The OIG reviewed tracking records and found maintenance documents for only one bed. The Joint Commission requires staff to inspect, test, and maintain medical equipment and document these activities.[39] When staff do not maintain equipment, there is a risk of harm or injury to patients and staff. The OIG recommends the Associate Director ensures the manufacturer satisfies contractual requirements to perform preventive maintenance for beds and stretchers and documents the service.

[38] In FY 2023, senior leadership attended environment of care rounds 71.1 percent of the time and staff closed 72.1 percent of identified environment of care deficiencies, or created an action plan to address them, within 14 business days.

[39] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, July 1, 2024.

PATIENT SAFETY

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[40] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[41] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

After reviewing the facility's policies and interviewing leaders, the OIG determined leaders had established processes to manage urgent, noncritical test result communications between both diagnostic and ordering providers, and providers and patients. The OIG found the policies aligned with the updated VHA directive.[42]

Action Plan Implementation and Sustainability

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

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[43] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether action plans were implemented, effective, and sustained.

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

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

[42] VHA Directive 1088(1).

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

The OIG reviewed the most recently published OIG report and found no open recommendations.[44] The Patient Safety Manager confirmed the facility had no open action plans related to the communication of test results. The OIG did not identify barriers to staff initiating, implementing, or monitoring action plan improvements.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[45] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[46] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

During interviews, leaders shared various practices for identifying opportunities for process improvements:

- The Patient Safety Manager tracks patient events.
- The Risk Manager evaluates quality indicators related to the peer review process.[47]
- The Chief of Primary Care formally evaluates clinicians by reviewing clinic notes.

The Patient Safety Manager and Risk Manager said they work collaboratively and share lessons learned with each other. The Chief of Quality Management described also sharing lessons learned with Veterans Integrated Service Network (VISN) and facility leaders.[48]

[44] VA OIG, *Comprehensive Healthcare Inspection of the VA Connecticut Healthcare System in West Haven*, Report No. 21-00266-281, September 29, 2021.

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

[46] VHA Directive 1050.01(1).

[47] A peer review "is a critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

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

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[49] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[50] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[51] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[52] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[53] The Primary Care Management Module Coordinator described meeting regularly with primary care leaders to discuss panel sizes and adjusting them to ensure they are reasonable.

During an interview, primary care leaders informed the OIG of vacancies for approximately 20 registered nurses, licensed practical nurses and medical support assistants. The Chief Nurse of Primary Care described challenges with recruitment efforts, noting the private sector offered licensed practical nurses higher wages. Primary care leaders redistributed workload and used virtual capabilities, including the VISN's Clinical Resource Hub, to cover the vacancies.[54] The

[49] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

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

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

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

[53] VHA Directive 1406(1).

[54] Clinical Resource Hubs allow veterans to receive care at their local facilities from providers at another location through telehealth technology. "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed May 22, 2024, https://www.patientcare.va.gov/primarycare/CRH.asp. Virtual clinics are a way to meet with the primary care team without traveling to the office. "VA Telehealth," Department of Veterans Affairs, accessed December 18, 2024, https://telehealth.va.gov/type/home.

Chief of Primary Care added that there were only a few vacancies for providers, but candidates had been selected for those positions.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[55] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care leaders and staff said the VISN call center significantly affects efficiency, increases staff's workload, and risks patient safety. Primary care leaders said call center staff had directed veterans requesting medication refills to the pharmacy when they could have been mailed. Staff added that when veterans contact the call center, the primary care team receives an alert even if the information was meant for a different provider. Staff expressed concerns regarding an estimated additional 75 to 100 alerts per day, per team, from the call center. Staff added that when the call center receives a veteran's request for a same day appointment, instead of scheduling the appointment, call center staff send a message to the primary care team. Primary care staff said this process could delay care because they are caring for other veterans and could miss an urgent issue.

The Chief of Primary Care described meetings with workgroups that include facility and call center staff about the issues; the workgroups evaluated different ways to improve the call center's functionality, but the problems persisted. The OIG recommends the Veterans Integrated Service Network Director works with facility and primary care leaders to address the network call center's effect on primary care team efficiency and workload and reduce the risk of adverse patient safety events.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG reviewed enrollment data from the prior three years and found a slight decrease in the number of veterans enrolled at the facility. In an interview, the Chief of Primary Care said enrollment had increased following the act's implementation, but the overall number of veterans enrolled at the facility declined because they left the area due to cold weather and the higher cost of living compared with other places. Primary care leaders and staff agreed there were no changes in primary care team efficiency, and wait times for new and established patients remained stable since the PACT Act's implementation.

[55] VHA Handbook 1101.10(2).

VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

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

The HCHV Director said the facility had a dedicated primary care team that provided services to homeless veterans or veterans at risk of experiencing homelessness in the community. The team used a mobile care unit that included exam rooms.

Figure 10. *Best practice for veteran engagement and care. Source: OIG interview.*

Identification and Enrollment of Veterans

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

The facility did not meet the HCHV5 target in FYs 2021, 2022, and 2023. The HCHV Director attributed it to staff failing to document assessments for every veteran seeking homeless services. The HCHV Director educated staff on engaging with veterans and documenting their encounters and going to local hospitals to identify and assist unsheltered veterans.

The HCHV Director said program staff and partners assist veterans with applying for VA benefits and their housing, legal, financial, food, and vocational needs. The HCHV Director

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

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

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

shared that the facility's Community Resource and Referral Center also provided shower and laundry facilities for homeless veterans.[59]

Based on an OIG questionnaire, program staff indicated they visit community shelters, soup kitchens, food banks, hospitals, libraries, and outdoor spaces with homeless encampments to identify unsheltered veterans. The HCHV Director added that facility staff and those from community and state organizations refer veterans to the program.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[60]

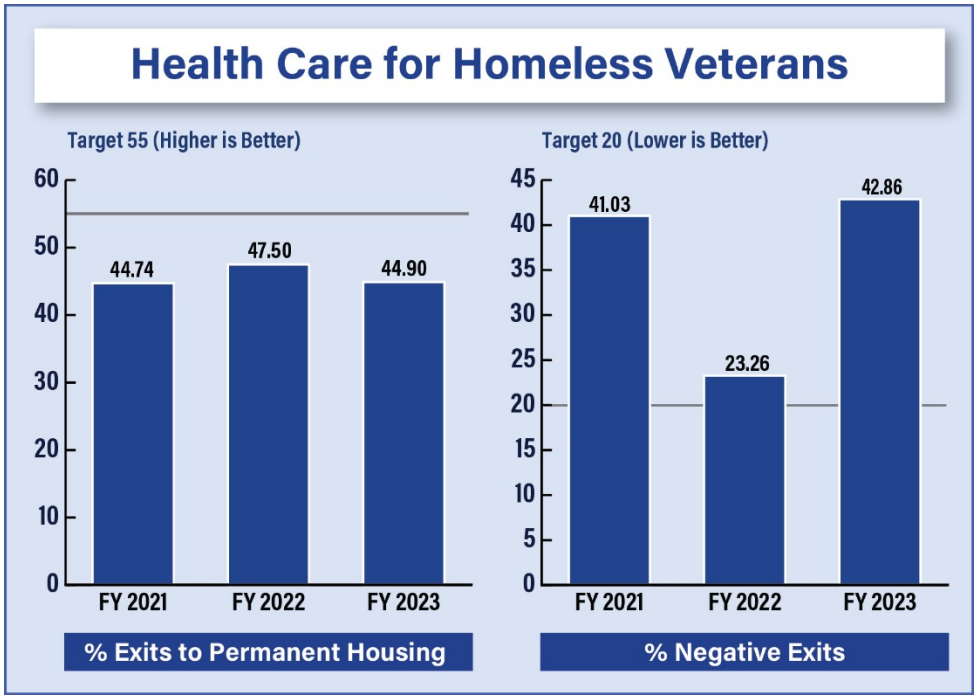

Figure 11. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

[59] "Community Resource and Referral Centers provide veterans who are homeless and at risk of homelessness with one-stop access to community-based, multi-agency services to promote permanent housing, health, and mental health care, career development and access to VA and non-VA benefits." "VA Homeless Programs, Community Resource and Referral Centers (CRRCs)," Department of Veterans Affairs, accessed April 23, 2025, https://www.va.gov/HOMELESS/Crrc.asp.

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

The program did not meet the HCHV1 or HCHV2 targets for FYs 2021 through 2023. The HCHV Director stated some veterans did not like staying in temporary housing that was based out of a shelter and therefore would leave before being permanently housed. The director discussed strategies to improve performance, such as meeting regularly with enrolled veterans and contract residential program staff to work toward better housing outcomes.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[61] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[62]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[63] The facility did not meet the target during FY 2023. The Veterans Justice Outreach Specialist attributed this, in part, to the pandemic; courts significantly delayed cases, which limited program referrals in FYs 2022 and 2023.

The specialist stated that staff and employees at local hospitals, courts, Jail Diversion programs, and the Connecticut Veterans Legal Center refer veterans to the program, and some veterans refer themselves.[64] At the time of the inspection, the specialist reported increasing outreach to jails, prisons, courts, and community partners to enroll more veterans and meet the target.

Figure 12. *A program success story. Source: OIG interview.*

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

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

[63] 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*.

[64] The Connecticut Veterans Legal Center provides free legal assistance to help veterans in the state to "overcome legal barriers to housing, healthcare, income, and recovery." "Connecticut Veterans Legal Center," Connecticut Veterans Legal Center, accessed August 14, 2024, https://ctveteranslegal.org. The Jail Diversion program assists adults involved in the criminal justice system that meet the Department of Mental Health and Addiction Services' psychiatric disabilities criteria. "February 2022 Innovation Spotlight, Connecticut Jail & Court Diversion, National Judicial Task Force to Examine State Courts' Response to Mental Illness," National Center for State Courts. On August 14, 2024, the website contained this information (it has since been removed from their website).

Meeting Veteran Needs

The Veterans Justice Outreach Specialist informed the OIG that enrolled veterans need housing, medical and mental health care, and substance use treatment. In an OIG-administered questionnaire, a program staff member indicated one of the program's objectives is to assist veterans with getting access to VA services and programs. The Veterans Justice Outreach Specialist added that staff work with community partners to provide interim housing solutions to veterans.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[65] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[66]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[67] The program did not meet the target in FYs 2021, 2022, or 2023.

The acting Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager reported low housing availability and high rents as barriers to meeting the target, in addition to challenges finding housing for veterans with low credit scores, legal issues, or eviction histories. The acting manager also said that during the pandemic, some housing authorities closed, and community programs reduced their services. To address these barriers, the acting manager cited increased communication with the local housing authority to discuss ways

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

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

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

to streamline the process, and a partnership with Supportive Services for Veteran Families, who offered incentives to landlords willing to rent to enrolled veterans.[68]

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[69] The facility met the target in FY 2022 but not FY 2023.

The acting Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager said staff did not always update veterans' employment status in the database, and this incorrect data contributed to the program missing the target in FY 2023. The acting manager added the program has an employment coordinator who connects veterans to vocational resources in the community and works with landlords to see if they can offer jobs to homeless veterans.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

[68] Supportive Services for Veteran Families "provides case management and supportive services to prevent the imminent loss of a Veteran's home or identify a new, more suitable housing situation for the individual and his or her family; or to rapidly re-house Veterans and their families who are homeless and might remain homeless without this assistance." "Supportive Services for Veteran Families," Department of Veterans Affairs, accessed August 14, 2024, https://www.va.gov/homeless/ssvf/index.html.

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

OIG Recommendations and VA Responses

Finding: A veteran service organization respondent to an OIG questionnaire reported veterans' concerns with the lack of direct phone communication with their care teams. Facility leaders were aware of veterans' complaints about unanswered phone calls by care teams but had not resolved the problem.

Recommendation 1

The OIG recommends facility leaders develop and implement a plan to address veterans' unanswered phone calls.

__X__ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

To ensure calls are being addressed in a timely manner an interdisciplinary team (IDT) will be developed by July 31, 2025, to review all patient complaints surrounding calls in addition to established metrics including percent abandoned, handle time, and speed of answer for each individual call. The IDT will focus on improving efficiency and effectiveness of the customer experience related to the phones. Updates on the IDT's identified areas of opportunity, patient complaints through the PATs-R and V-Signal tracking system, quality metrics, and corrective actions will be reported out monthly through the Quality, Safety, and Value Council and tracked through the Governing Board with measurement noted as an agenda item for six consecutive months for compliance of 90% or greater.

Finding: The facility did not meet VHA's performance measure target for staff identifying one or more environment of care trends and submitting performance improvement action plans with outcome measures to the Associate Director in FYs 2023 or 2024.

Recommendation 2

The OIG recommends the Associate Director ensures staff identify environment of care trends and establish performance improvement plans with outcome measures to address them.

__X__ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The current Environment of Care Committee (EOCC) charter will be reviewed and updated by the Acting Associate Director and Acting Safety Service Chief to reflect compliance with VHA Directive 1608(1) Comprehensive Environment of Care Program. The EOCC committee is a multidisciplinary group that will review the most reported issues identified in weekly environment of care rounds. A continuous performance improvement plan, including outcome measures, will be a standing agenda item for the committee. Compliance will be met after six (6) consecutive months of minutes of the Environment of Care Committee show discussion of environment of care trends as a standing agenda item.

Finding: Multiple beds and a stretcher in patient care areas had no evidence of required preventive maintenance. The Associate Chief of Facilities Management Services stated the manufacturer performs the maintenance, but the OIG reviewed tracking records and found documentation of maintenance for only one bed.

Recommendation 3

The OIG recommends the Associate Director ensures the manufacturer satisfies contractual requirements to perform preventive maintenance for beds and stretchers and documents the service.

__X__ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

Preventative maintenance for beds and stretchers services are performed by vendor. Contract monitoring for this service is transitioning from Facilities Management Service to Clinical Engineering. Clinical engineering staff will ensure compliance with the vendor performed preventative maintenance with periodic rounds throughout the hospital to ensure updated stickers are appropriately placed on all designated beds and stretchers noted on the vendor issued report. Rounding will continue until 6 consecutive months of 90% or higher compliance is met. Numerator will be number of pieces of medical equipment with the correct stickers, denominator will be total number of pieces of medical equipment audited.

Finding: Primary care leaders and staff conveyed to the OIG that the VISN call center was a significant issue affecting efficiency, increasing staff's workload, and potentially risking patient safety. The staff explained that a veteran contact through the call center generated an alert to the primary care team, but the alert did not necessarily reach the correct provider. Staff expressed concerns regarding the estimated additional 75 to 100 alerts per day, per team, from the call center. Staff also stated that when the call center received a veteran's request for a same day appointment, instead of scheduling the appointment, call center staff sent a message to the primary care team requesting the appointment. Primary care staff said they believed this process could cause delays in care and even an adverse event because an urgent issue may not be addressed for several hours.

Recommendation 4

The OIG recommends the Veterans Integrated Service Network Director works with facility and primary care leaders to address the network call center's effect on primary care team efficiency and workload and reduce the risk of adverse patient safety events.

__X__ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

The Veterans Integrated Service Network (VISN) 1 Clinical Contact Center (CCC) has already begun to collaborate with Primary Care (PC) to address concerns on clinical workload and efficiency related to call center processes. A Power App titled, *VISN 1 Clinical Contact Center Internal Issue Reporting*, was developed, by the VISN, for facilities to document all concern

with CCC. Two areas for improvement have been identified, specifically for the process on distributing view alerts and same day scheduling.

The VISN 1 CCC and Connecticut PC leaders will continue their collaboration by conducting a monthly meeting to discuss cases documented in the *VISN 1 Clinical Contact Center Internal Issue Reporting system*. The VISN 1 CCC will compile a monthly report outlining action plans that have evolved from the meeting. The report will include trending of concerns and any associated reported safety incidents (both actual and near misses). These reports will be submitted to the VISN PC Management Board and escalated up to the VISN 1 Quality Patient Safety Committee. This plan will be ongoing until there is 6 months of compliance with sustained results in a decrease in the number of reported view alerts (baseline of 75 per day).

Appendix A: Methodology

Inspection Processes

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from July 23 through 25, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in May 2024.

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 4, 2025

From: Director, VA New England Healthcare System (10N01)

Subj: Healthcare Facility Inspection of the VA Connecticut Healthcare System in West Haven

To: Director, Office of Healthcare Inspections (54HF04)

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

1. Thank you for the opportunity to review and comment on the draft report regarding the healthcare inspection report at the VA Connecticut Healthcare System. The VA New England Healthcare System is committed to providing exceptional healthcare to Veterans.
2. I thank the OIG team for their recommendations which identified areas for improvement.
3. The leadership teams at VA Connecticut Healthcare System and the Veterans Integrated Network Office are committed to implementing corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans that we serve.

(Original signed by:)

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

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 9, 2025

From: Executive Director, VA Connecticut Healthcare System (689)

Subj: Healthcare Facility Inspection of the VA Connecticut Healthcare System in West Haven

To: Director, VA New England Healthcare System

1. Thank you for the opportunity to review and respond to the draft report from the Healthcare Facility Inspection of the VA Connecticut Healthcare System in West Haven, Connecticut.
2. I have reviewed the report and concur with all findings and recommendations as written. VA Connecticut Healthcare System is committed to continually improving of the quality of care provided to our Veterans.

(Original signed by:)

Becky D. Rhoads, Au.D.
Executive Director
VA Connecticut Healthcare System

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