US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Boston Healthcare System in Massachusetts

Healthcare Facility Inspection	24-00613-162	July 10, 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 Boston Healthcare System (facility) from August 6 through 8, 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. The executive leaders described the COVID-19 pandemic as a system shock that resulted in staffing and care delivery improvements. These included the use of virtual appointments to offer more frequent mental health sessions, postoperative telehealth appointments for veterans who live far from the facility, and telework to allow staff to share spaces in the facility's clinic areas.[2]

Leaders described using daily briefings (tiered huddles) as part of their communication processes.[3] Survey results from fiscal years 2021 through 2023 for three questions (related to

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

[2] The site visit occurred in August 2024, which pre-dates the "Return to In-Person Work" Presidential Order, dated January 20, 2025. Return to In-Person Work, 90 Fed. Reg. 8251 (January 28, 2025); "Return to In-Person Work," The White House, January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/return-to-in-person-work. The OIG cannot comment on VA's plan of action to comply with the Presidential Order.

[3] Tiered huddles are daily communications to multiple levels of staff (i.e., frontline staff, service-level leaders, and executive leaders) as part of the HRO journey. VHA, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

fear of reprisal, supervisor trust, and psychological safety) were equal to or higher than VHA averages. Leaders explained the facility was named one of *The Boston Globe's* Top Places to Work, and they used this designation on recruitment materials.

Additionally, Patient Experience Coordinator staff and veterans service organization representatives stated that leaders were responsive to veterans' concerns about parking.[4] In response to parking concerns, leaders said they reinstated valet parking in March 2024 at the Jamaica Plain VA Medical Center. The Director also described being aware of an issue with the way veterans' phone calls were routed to clinic staff, and acknowledged there were opportunities to improve the process.

Environment of Care

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

The OIG was able to navigate to all three of the facility's medical centers in West Roxbury, Brockton, and Jamaica Plain. Crosswalks at the West Roxbury VA Medical Center lacked detectable warning surfaces, which alert people with visual impairments of their approach to traffic. However, staff explained a current construction project will include the installation of warning surfaces.

The main entrances of the three medical centers had passenger loading zones, power-assisted doors, and a supply of wheelchairs available. The main entrance lobbies were generally clean and well-lit, with seating areas and information desks staffed with employees or volunteers. All three medical centers had color maps on the walls in multiple buildings, and information desk employees and volunteers provided printed maps to assist in navigation. Multiple features were available to assist individuals with visual impairments navigate the facility.

However, the OIG found multiple issues with cleanliness that had previously been identified in oversight reports, including dust on a refrigerator that contains patient food, rusty poles used to hold intravenous bags, expired hand sanitizer, dirty ventilation grills, stained and dusty ceiling tiles, and dirty and clean equipment stored together.[5] The OIG also observed dusty bed and examination table frames, dirty ice machines with one past due for routine sanitation, bottom

[4] Veterans Service Organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

[5] The Joint Commission, *Final Accreditation Report VA Boston Healthcare System,* May 23, 2024 (this report is not publicly accessible); VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts*, Report No. 17-05570-06, October 23, 2018.

storage shelves which were too close to the floor, and items stored in corrugated boxes.[6] The OIG issued three recommendations to address these issues.

The OIG also observed areas containing biohazardous items lacked appropriate signage, which could pose a safety risk to staff.[7] Additionally, the OIG found deficiencies with medication storage including unlicensed personnel access to medication, lack of temperature and humidity monitoring for medication storage areas, and unapproved rooms being used for medication storage. Lack of appropriate medication security and storage can compromise patient safety. The OIG issued five recommendations regarding biohazard signage and medication storage.

Further, VHA requires staff to identify at least one environment of care trend and establish a performance improvement plan.[8] The OIG found that facility staff had not identified an environment of care trend to track and monitor during the fiscal year and made a related recommendation.

The OIG also noted concerns with the operation of the Urgent Care Center at the Brockton VA Medical Center. The Urgent Care Center was an Urgent Care Level III and operated 24 hours per day, seven days a week.[9] Although a VHA directive states that urgent care centers are usually not open 24 hours a day, facility staff had previously obtained a waiver from the VHA National Program Office of Emergency Medicine that allowed all-day operation.[10] The OIG reviewed the facility's most recently approved version of the waiver and found it had expired in March 2023, when VHA published an updated directive. A facility leader reported being unaware of the expiration and had not sought an updated waiver.[11]

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[6] "The lowest shelves in storage areas must be solid and must have at least eight inches of space between the floor and bottom shelf. This space will allow access for cleaning to avoid contamination." VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020. Corrugated boxes are an infection control concern because they can house pests, droppings, and larva, which can later become an infestation. "Standards FAQs, Boxes and Shipping Containers, What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed May 5, 2025, https://www.jointcommission.org/standards/LifeSafety.

[7] "Biological hazard signs. The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents." 29 C.F.R. § 1910.145(e)(4).

[8] Acting Assistant Under Secretary for Health for Support (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1023), May 10, 2024.

[9] "Urgent Care provides outpatient acute medical care for patients without a scheduled appointment who need prompt attention for an acute medical or mental health illness or minor injuries that are significant but not life threatening." An Urgent Care Level III center "provides treatment for low acute minor illnesses and injuries." VHA Directive 1101.13, *VHA Urgent Care,* March 20, 2023.

[10] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017 (VHA rescinded and replaced this directive with VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023); VHA Directive 1101.13.

[11] VHA Directive 1101.13.

Additionally, the OIG noted a concern with potential staffing levels at the Urgent Care Center. Leaders reported there was always one urgent care practitioner on the medical center site; however, they respond to patient emergencies in other locations at the medical center, leaving the urgent care center without a practitioner. The OIG identified this practice as a deviation from the current and prior VHA directives, and it was not included in the expired waiver.[12] The Chief of Emergency Services reported believing the expired waiver allowed for the practitioner to leave the Urgent Care Center to respond to emergencies. The OIG made one recommendation related to the Urgent Care Center.

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. No recommendations from prior OIG reports remained open (although the OIG found problems with action plan sustainment, as discussed above), and staff were able to explain their process improvement program. The facility also had an approved policy to address communication of test results but had only recently implemented an audit process to monitor the communication of test results to veterans.

However, the OIG found the facility had a local policy designating Emergency Department and Urgent Care Center staff to receive after-hours communication of critical test results, despite VHA's requirement that emergency departments should not be the default location to receive these notifications. The OIG made one related recommendation.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[13]

The facility had 49 primary care teams that averaged 89 percent full according to VHA's recommended panel size (the number of patients assigned to a care team). A primary care leader reported using float providers (staff who do not belong to a specific team) to cover for leave and vacancies. In interviews, primary care staff reported panel sizes were manageable given their

[12] VHA Directive 1101.13; VHA Directive 1101.05(2); VHA Directive 1101.14.

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

current staffing. The staff stated they were comfortable bringing forth concerns, and PACT Act implementation had not affected primary care work.

The Patient Centered Management Module is a computer program that allows staff to track primary care data.[14] The Principal Facility Coordinator for the Patient Centered Management Module reported being trained by the supervisor but not receiving formal education at the national VHA level for the coordinator role. The OIG noted a concern with a lack of formalized training for the Principal Facility Coordinator for the Patient Centered Management Module, which may lead to inconsistencies in how staff use data to optimize primary care teams.[15]

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. Staff collaborated with community partners to help provide temporary housing options for veterans. For example, one community program focused on identifying and tracking homeless veterans who used emergency care services more than 10 times within six months and the Health Care for Homeless Veterans team worked to facilitate medical care and housing for this population. Another community partner dedicated 18 emergency beds to veterans for temporary shelter.

Program staff discussed challenges in assigning housing vouchers to veterans because some veterans who applied did not have all the required documents, as well as occasional difficulty locating veterans during the application process. Additionally, staff explained some difficulties, such as the high cost of living in and around the Boston area; rent exceeding what the housing authority was able to pay; and veteran-specific issues, such as lack of landlord references, poor credit scores, and legal concerns that made it challenging to secure housing.

The Veterans Justice Program Supervisor described that when staff identify veterans who qualify for program services, program specialists have a 48-hour engagement goal to schedule an assessment. The supervisor said one way they identify veterans is by using information obtained from a software program used by jails, prisons, and courts.

What the OIG Recommended

The OIG made 11 recommendations.

[14] The "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." VHA Directive 1406(1), *Patient Centered Management Module (PCMM) for Primary Care,* June 20, 2017, amended April 17, 2024

[15] "The principal facility coordinator (PFC) is the facility's designated staff member who manages and maintains the access, data entry, and accuracy of PCMM [Patient Centered Management Module]." VHA Directive 1406(1).

1. The Director ensures staff have processes to prevent repeat environment of care findings.
2. The Veterans Integrated Service Network 1 Director monitors for similar or repeated environment of care findings and ensures facility staff sustain improvements.
3. The Veterans Integrated Service Network 1 Director ensures facility leaders identify environment of care trends and establish performance improvement plans with outcome measures to address them.
4. The Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present.
5. The Director ensures staff keep patient care areas clean and safe.
6. The Director ensures only authorized staff have access to medication storage areas.
7. The Director ensures staff conduct an inventory of all the facility's medication storage areas, and the Chief of Pharmacy approves them.
8. The Chief of Pharmacy ensures pharmacy staff inspect each approved medication storage area monthly.
9. The Director ensures staff monitor temperature and humidity in medication storage areas and track possible deviations, even those that may occur when the areas are closed.
10. The Director ensures the Brockton VA Medical Center's Urgent Care Center operates according to VHA Directive 1101.13 and obtains an appropriate waiver from the VHA National Program Office of Emergency Medicine as applicable.
11. Facility leaders review the local policy to ensure it complies with VHA directives specific to which staff receive notification of critical test results.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with recommendations 1 and 3-11, concurred in principle with recommendation 2, 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 considers recommendation 10 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

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 Boston Healthcare System
Boston, Massachusetts
Level 1a-High Complexity
Suffolk County
Hospital Referral Region: Boston

Description of Community

POPULATION

Female **3,528,830**	Male **3,356,397**
Veteran Female **26,631**	Veteran Male **281,666**

Homeless - State **15,507**
Homeless Veteran -State **534**

MEDIAN INCOME

$85,221

EDUCATION

94% Completed High School
72% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **321**

SUBSTANCE USE

33.4% Driving Deaths Involving Alcohol
23.1% Excessive Drinking
2,492 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	2,459,992
Public Transportation	333,920
Work at Home	304,399
Carpool	257,413
Walk to Work	163,091
Other Means	74,121

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**19 Minutes, 12 Miles**
Specialty Care	**29 Minutes, 24 Miles**
Tertiary Care	**58 Minutes, 48 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **19,543**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	37%
<65 without Health Insurance	5%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

13,615

N/A VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.63 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

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

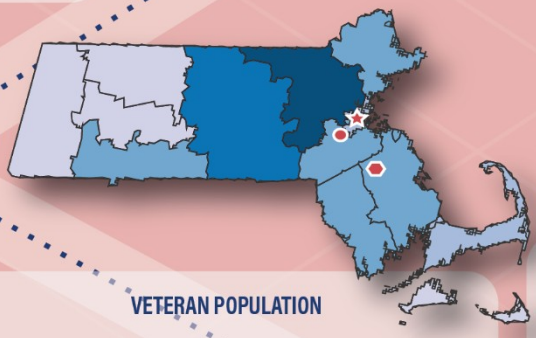
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	61K
Unique Patients VA Care	59K
Unique Patients Non-VA Care	8K

COMMUNITY CARE COSTS

Unique Patient	Outpatient Visit
$29,785	$359
Line Item	**Bed Day of Care**
$2,228	$321



STAFF RETENTION

Onboard Employees Stay <1 Yr	8.02%
Facility Total Loss Rate	10.29%
Facility Retire Rate	2.48%
Facility Quit Rate	6.75%
Facility Termination Rate	0.89%

VETERAN POPULATION

0.22% 3.84% 7.44% 11.05% 14.65% 18.25%

- Brockton VA Medical Center
- Jamaica Plain VA Medical Center
- West Roxbury VA Medical Center

The VA Boston Healthcare System includes the Jamaica Plain VA Medical Center, West Roxbury VA Medical Center, and Brockton VA Medical Center. The OIG visited all three sites.

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]

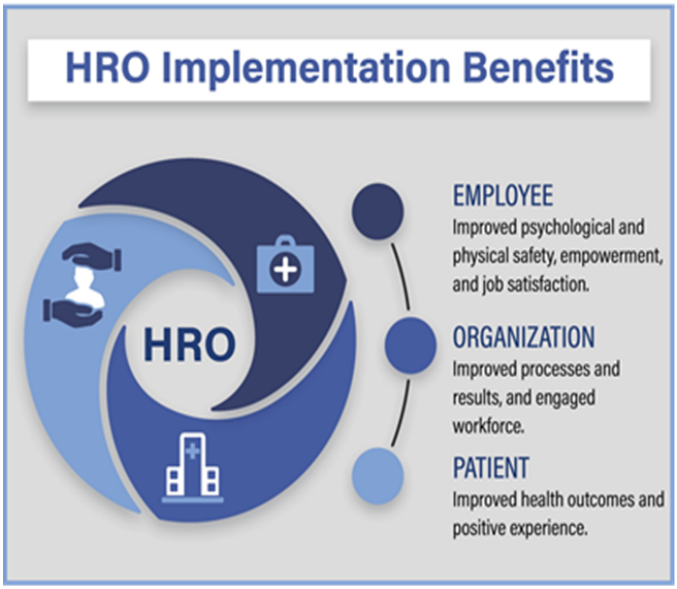


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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 operations.

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

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

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

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

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

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

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

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.

In 1999, VA merged the medical centers at West Roxbury, Brockton, and Jamaica Plain, which originally opened in 1943, 1953, and 1952, respectively, to create the VA Boston Healthcare System (facility).[13] The facility's most recent addition is the Neuroscience Research building at the Jamaica Plain VA Medical Center, completed in 2022.

At the time of the inspection, the facility's executive leaders consisted of the Director, Deputy Director, Chief of Staff, Associate Director for Patient Care Services, Associate Directors for the Jamaica Plain and Brockton VA Medical Centers, and Assistant Director for the West Roxbury VA Medical Center.[14] The newest member of the leadership team, the Deputy Director, was assigned in December 2023. The Associate Director for Patient Care Services, assigned in June 2000, and the Chief of Staff, assigned in June 2003, were the most tenured.

The facility's Chief Financial Officer reported the budget was approximately $881 million in fiscal year (FY) 2023. The business office Management and Program Analyst said the facility had 517 operating beds at the West Roxbury and Brockton medical centers.[15] The bed types for both locations included medical/surgical, community living center, spinal cord injury, domiciliary, mental health, and compensated work therapy transitional residence beds.[16]

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

[13] "VA Boston Health Care, About Us," Department of Veterans Affairs, accessed September 11, 2024, https://www.va.gov/boston-health-care/about-us/history/.

[14] At the time of the inspection the Chief of Staff was unavailable, so the OIG interviewed the Deputy Chief of Staff with the other executive leaders.

[15] The Jamaica Plain VA Medical Center provides primary care and specialty outpatient services.

[16] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed April 3, 2025, 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 April 3, 2025, https://www.va.gov/homeless/dchv. Compensated work therapy assists veterans with resources and support to return to the work force. "Compensated Work Therapy," Department of Veterans Affairs, accessed April 3, 2025, https://www.va.gov/Health/CWT.

"below-average performance in patient outcomes or quality of care metrics."[17] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[18] 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).[19]

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.[20] 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.[21] 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.

The executive leaders explained the COVID-19 pandemic had been a system shock that resulted in sustained improvements in care delivery and staffing flexibilities. For example, they said staff provided more frequent virtual mental health therapy sessions for veterans. Additionally, the leaders used virtual postoperative care, which allowed veterans who may live far from the facility to have a video call with the surgeon to assess healing during appointments with their local healthcare provider. They also explained staff telework and provide virtual care so other staff and patients can use the on-site spaces.[22]

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[17] 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.

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

[19] 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.

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

[21] 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*.

[22] The site visit occurred in August 2024, which pre-dates the "Return to In-Person Work" Presidential Order, dated January 20, 2025. Return to In-Person Work, 90 Fed. Reg. 8251 (January 28, 2025); "Return to In-Person Work," The White House, January 20, 2025, https://www.whitehouse.gov/presidential-actions/2025/01/return-to-in-person-work. The OIG cannot comment on VA's plan of action to comply with the Presidential Order.

Further, the leaders pointed out that scheduling flexibilities, like telework, are also recruitment and retention tools. The Director added that because of the facility's metropolitan location, they contract with other VHA facilities, in locations such as Colorado and Alabama, to virtually provide specialty care services.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[23] 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.[24] 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."[25]

Figure 4. *Leader communication with staff.*
Source: OIG interviews with facility leaders.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[26] The executive leaders shared that communication efforts, such as daily briefings (tiered huddles), rounding (visiting staff in their hospital workspaces), and routinely meeting with union leaders, provided opportunities to identify both successes and areas for improvement.[27]

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

[24] 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*.

[25] 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.

[26] 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.

[27] Tiered huddles are daily communications to multiple levels of staff (i.e., frontline staff, service-level leaders, and executive leaders) as part of the HRO journey. VHA, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[28] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[29] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

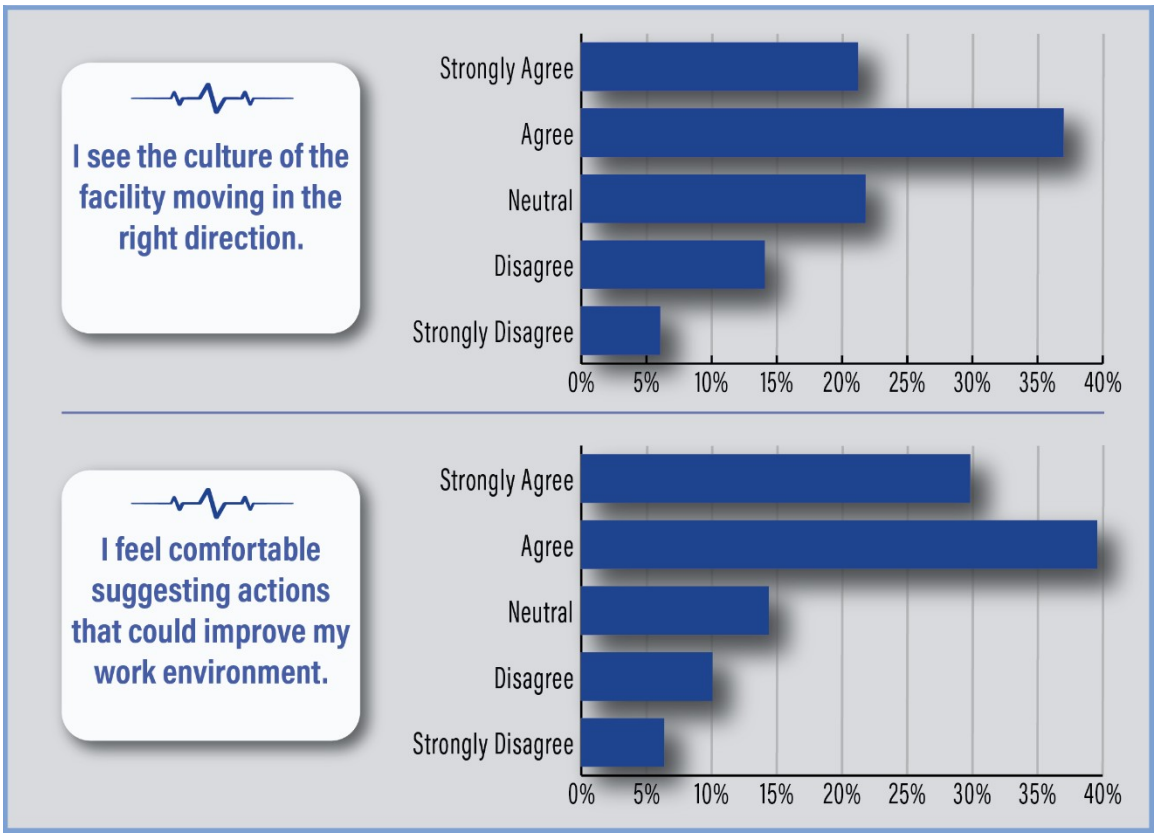

Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The OIG found the All Employee Survey results from FYs 2021 through 2023 for three questions (related to fear of reprisal, supervisor trust, and psychological safety) stayed generally the same and were equal to or higher than VHA averages. The leaders explained their approach

[28] "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.

[29] 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.

to survey results was to pair employees from areas with higher scores with employees in areas with opportunities for improvement to encourage them to learn from those who have had success. Additionally, the leaders used the results to coordinate their rounding schedule to share information with employees in work areas that need improvement. The Director also shared that the facility had received *The Boston Globe*'s Top Places to Work designation for 13 of the past 15 years.[30] The Director added they used *The Boston Globe*'s logo with this distinction on their recruitment materials.

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.[31] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[32] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

The VSOs and Patient Experience Coordinator shared examples of veterans' complaints about parking, appointment and telephone wait times, and disrespectful behavior from staff, but reported facility leaders are responsive to these concerns. The Director acknowledged being aware of veterans' telephone and parking concerns, explaining that all clinic telephone calls come through the Veterans Integrated Service Network (VISN) call center, which frustrates veterans.[33] The Director stated this process has opportunities for improvement. In response to parking concerns at the Jamaica Plain VA Medical Center, leaders said they reinstated valet parking in March 2024.

[30] "VA Boston Healthcare System," Top Work Places, accessed April 3, 2025, https://topworkplaces.com/company/va-boston-healthcare/boston/; "Massachusetts Top Workplaces 2023," Top Work Places, accessed December 2, 2024, https://topworkplaces.com/award/boston/2023.

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

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

[33] 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/.

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.[34] 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. *Photos of the facility, from left to right: West Roxbury, Jamaica Plain, and Brockton VA Medical Centers. Source: "VA Boston Health Care," Department of Veterans Affairs, accessed July 29, 2024, https://www.va.gov/BostonHealthCare.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[35] 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.[36]

[34] VHA Directive 1608(1).

[35] 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.

[36] 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.

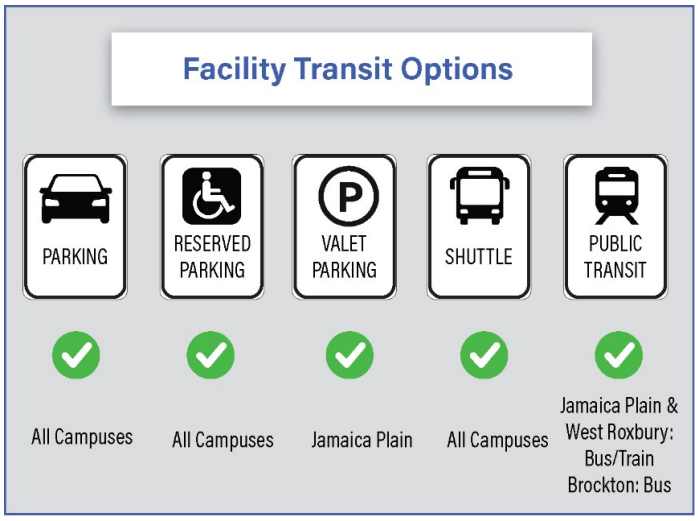

Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The OIG used a commercial navigation application to travel to the facility's three medical centers and found the directions easy to follow. The OIG noted each site had signs directing veterans and visitors to parking and building locations. However, while driving around the Brockton VA Medical Center, the OIG saw limited directional signage to the Urgent Care Center, which is open 24 hours, seven days a week; this could potentially delay treatment.[37] The OIG suggests facility leaders consider improving exterior directional signage to the Brockton VA Medical Center's Urgent Care Center, as warranted.

Main Entrance

Figure 8. *Photo of the courtyard outside the Primary Care Clinic at West Roxbury VA Medical Center.*
Source: Photo taken by OIG inspector.

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.[38] The OIG noted the main entrances of the three medical centers had passenger loading zones, power-assisted doors, and a supply of wheelchairs available. Additionally, the OIG found the main entrance lobbies generally clean and well-lit, with seating areas and information desks staffed with employees or volunteers to assist veterans and visitors.

[37] "Appropriate signage indicating convenient access for all individuals presenting for care must be placed at major points of entrance into the VA medical facility and must clearly indicate directions to access Urgent Care during operational hours." VHA Directive 1101.13, *VHA Urgent Care,* March 20, 2023.

[38] 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*.

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 whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[39]

At all three medical centers, the OIG found color maps on the walls in multiple buildings, and information desk employees or volunteers who provide printed maps to assist in navigation. In addition, the OIG inspectors were able to use the navigational cues and wall directories to find their way around.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[40] During the inspection, the OIG found multiple features available to assist individuals with visual impairments navigate the facility, such as large print maps. Additionally, the information desk employees and volunteers reported they could help those with visual impairments get to their locations.

Information desk employees and volunteers also explained they communicate with individuals with hearing impairments through writing, and the OIG observed signs at all three information desks with instructions for accessing interpreter services. Additionally, the OIG found televisions in common areas using closed captioning to accommodate individuals with hearing impairments.

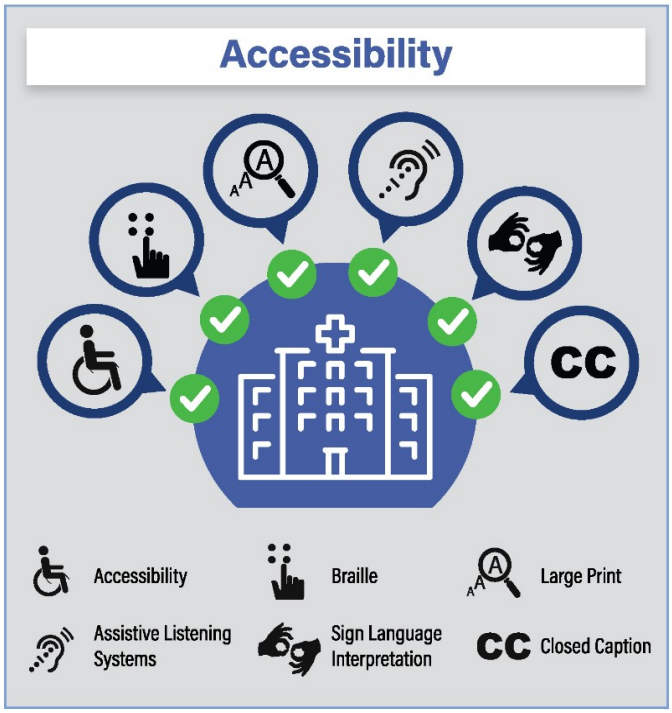

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG questionnaire responses and observations.

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

[40] 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.

However, the OIG observed crosswalks at the West Roxbury VA Medical Center adjacent to parking lot construction that lacked detectable warning surfaces, which alert people with visual impairments of their approach to traffic.[41] Because the Chief of Engineering Services stated that installing detectable warning surfaces was part of the current parking lot construction project, the OIG did not make a recommendation.

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 based on VA's guidelines.[42] A toxic exposure screening navigator said the facility had three navigators, all of whom had other primary duties. One navigator described having adequate resources to complete their current responsibilities.

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.[43] 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.

VHA requires facilities to meet regulatory and accrediting bodies' requirements and ensure a "safe, clean health care environment that provides the highest standards in the health care setting."[44] The OIG reviewed a May 2024 Joint Commission Survey report that included findings of dust on ceiling tiles and on a refrigerator holding patient food, rusty poles used to hold intravenous bags, and expired hand sanitizer.[45] Although the facility provided action plans to The Joint Commission and reported they had completed several of them, the OIG observed similar findings (dust and expired hand sanitizer) throughout the facility and noted staff had not sustained improvements or evaluated the deficiencies identified by Joint Commission across the

[41] VA Manual PG 18-10, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

[42] 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.

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

[44] VHA Directive 1608(1).

[45] The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation inspections in May 2024. The Joint Commission, *Final Accreditation Report VA Boston Healthcare System,* May 23, 2024. (This report is not publicly accessible.)

organization for improvement.[46] The Chief of Engineering Services explained the action plans addressed individual findings in specific locations, which staff had corrected.

Additionally, the OIG reviewed a prior OIG report with findings of dirty ventilation grills and stained ceiling tiles, and a recommendation that staff store dirty and clean equipment separately.[47] The OIG closed this recommendation after facility staff had provided evidence of improvement but observed similar deficiencies during the current inspection, showing staff had not sustained the improvement actions. The Acting Chief of Environmental Management Services was unable to provide a reason for lack of compliance. The OIG recommends the Director ensures staff have processes to prevent repeat environment of care findings. Additionally, the OIG recommends the VISN 1 Director monitors for similar or repeated environment of care findings and ensures facility staff sustain improvements.

VHA requires the Comprehensive Environment of Care Committee to identify at least one environment of care trend and submit a performance improvement plan with outcome measures to the Associate Director. Additionally, VHA requires VISNs to ensure staff correct environment of care deficiencies.[48] During an interview, the Chief of Engineering Services confirmed the committee had not identified any environment of care trends but provided no reason for this oversight. The OIG recommends the VISN 1 Director ensures facility leaders 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.

Besides the deficiencies noted above, the OIG observed several other problems. For example, areas where staff stored biohazardous items lacked biological hazard signs, which could pose a

[46] The facility's action plan for remediating the rusty poles used to hold intravenous bags was ongoing, but the OIG observed multiple rusty poles still in use. Staffs' plan of action was to assess for the rusty intravenous poles during environment of care rounds, which staff would conduct only twice per year in each clinical area, and for nurses to consult with supply staff to replace them.

[47] VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts*, Report No. 17-05570-06, October 23, 2018.

[48] Acting Assistant Under Secretary for Health for Support (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1023), May 10, 2024.

safety risk to staff.[49] In supply rooms, some shelves were not at least eight inches off the floor, which could result in contamination of supplies during floor cleaning.[50] In a patient care area, staff stored some items in corrugated boxes.[51] Multiple locations had dirty ice machines, and one ice machine was past due for routine cleaning. Finally, frames on the bottoms of patient beds and examination tables had dust.[52] The OIG recommends the Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present. In addition, the OIG recommends the Director ensures staff keep patient care areas clean and safe.

The OIG found another problem involving unsecured medication. VHA requires medications to be stored in a secure manner with access limited to authorized personnel.[53] In the Jamaica Plain VA Medical Center's Rose Clinic, the OIG observed unlicensed personnel (a certified nursing assistant) enter the locked medication room and then unlock the medication cart using the access code posted on the cart. The Quality Management Director for Medicine explained the nursing assistant was authorized to open the medication room door only and believed that all medications in the room were secured. Also in this room, the OIG found medications stored in unlocked cabinets and on the counter, making them accessible to anyone who had access to the room. The OIG recommends the Director ensures only authorized staff have access to medication storage areas.

Additionally, VHA requires the Chief of Pharmacy to approve all medication storage areas, pharmacy staff to inspect storage areas monthly, and the areas to meet certain temperature and humidity requirements.[54] At the Jamaica Plain women's health clinic, the OIG found that staff store medications in a room that pharmacy staff did not approve or monitor for this purpose. Despite pharmacy staff not approving the room for medication storage, the OIG found clinic staff monitor the room's temperature and humidity, including variations that occur during hours the clinic is closed.

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[49] "Biological hazard signs. The biological hazard warning shall be used to signify the actual or potential presence of a biohazard and to identify equipment, containers, rooms, materials, experimental animals, or combinations thereof, which contain, or are contaminated with, viable hazardous agents." 29 C.F.R. § 1910.145(e)(4).

[50] "The lowest shelves in storage areas must be solid and must have at least eight inches of space between the floor and bottom shelf. This space will allow access for cleaning to avoid contamination." VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020.

[51] Corrugated boxes are an infection control concern because they can house pests, droppings, and larva, which can later become an infestation. "Standards FAQs, Boxes and Shipping Containers, What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed May 5, 2025, https://www.jointcommission.org/standards/life-safety.

[52] VHA Directive 1608(1).

[53] VHA Directive 1108.07(2), *General Pharmacy Service Requirements,* November 28, 2022, amended October 4, 2023, and December 6, 2024.

[54] Examples of medication storage area requirements include staff maintaining the temperature between 68 and 77 degrees Fahrenheit (or according to the manufacturer's recommendations if different) and the relative humidity between 20 and 60 percent. VHA Directive 1108.07(2).

In the Jamaica Plain Green Clinic and Rose Clinic, the OIG noted pharmacy staff check medication rooms, but the clinic staff monitor the refrigerator temperature only. The logs did not include room temperature or humidity monitoring. Additionally, medication cabinets in the Rose Clinic had labeled shelves, but the OIG found most medications were not on the appropriately labeled shelf. For example, sodium chloride was in the location labeled for xylocaine.[55]

Despite pharmacy staff checking the Green and Rose clinics, staff did not identify concerns about safe medication storage. The facility's Chief of Pharmacy stated staff also track refrigerator temperatures using a commercial system, explaining the facility was in the process of upgrading to a commercial system for the room but had not yet activated it. The chief added that clinic staff should have used paper logs to document room temperature and humidity. The chief did not have a response about the shelf labeling problem.

Lack of appropriate medication storage can compromise patient safety. The OIG recommends the Director ensures staff conduct an inventory of all the facility's medication storage areas, and the Chief of Pharmacy approves them. The OIG also recommends the Chief of Pharmacy ensures pharmacy staff inspect each approved medication storage area monthly. Further, the OIG recommends the Director ensures staff monitor temperature and humidity in medication storage areas and track possible deviations, even those that may occur when the areas are closed.

The OIG also identified a challenge involving the Brockton VA Medical Center's Urgent Care Center. The Chief of Emergency Services said it was an Urgent Care Level III center and operated 24 hours per day, seven days a week.[56] Although a VHA directive states that urgent care centers generally do not operate on a 24 hour basis, the facility had previously obtained a waiver from VHA National Program Office of Emergency Medicine that allowed all-day operation.[57] The OIG reviewed the facility's most recently approved waiver and found it had expired in March 2023, when VHA published a new directive.[58] The Chief of Emergency Services reported being unaware of the expiration and had not sought an updated waiver.

The Chief of Emergency Services also explained there was always one urgent care practitioner on-site; however, the Urgent Care Nurse Manager reported the practitioner responds to patient emergencies in other locations at the medical center as well. The OIG identified this practice as a

[55] Sodium chloride is used to treat conditions such as dehydration. Xylocaine is a local anesthetic (numbing medication) used to help reduce pain during a procedure.

[56] "Urgent Care provides outpatient acute medical care for patients without a scheduled appointment who need prompt attention for an acute medical or mental health illness or minor injuries that are significant but not life threatening." An Urgent Care Level III center "provides treatment for low acute minor illnesses and injuries." "In general, Urgent Care does not operate 24 hours a day, 7 days a week." VHA Directive 1101.13.

[57] VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017 (VHA rescinded and replaced this directive with VHA Directive 1101.14, *Emergency Medicine*, March 20, 2023); VHA Directive 1101.13.

[58] VHA Directive 1101.13.

deviation from the current and prior VHA Directive, which requires a practitioner to be present in the Urgent Care Center at all times, and noted it was not included in the expired waiver.[59]

Despite the Chief of Emergency Services describing a belief the expired waiver allowed for a practitioner to leave the Urgent Care Center to respond to emergencies, the OIG is concerned that the waiver did not support this. The waiver allowed urgent care staff at the Brockton VA Medical Center to contact Emergency Department providers through telehealth at the West Roxbury VA Medical Center when they need assistance with patient care. The Chief of Emergency Services told the OIG that facility leaders had met with the VHA National Program Office of Emergency Medicine staff to discuss updating their waiver and were working through the submission and approval process. The OIG recommends the Director ensures the Brockton VA Medical Center's Urgent Care Center operates according to VHA Directive 1101.13 and obtains an appropriate waiver from the VHA National Program Office of Emergency Medicine as applicable.

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.[60] 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.[61] 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.

VHA required facility staff to develop a local policy about the communication of test results, including service-level workflows (which describe staff roles in the communication process),

[59] VHA Directive 1101.13; VHA Directive 1101.05(2); VHA Directive 1101.14.

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

[61] 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.

within 12 months.[62] The OIG reviewed the facility's local policy, which leaders amended July 31, 2024. Although leaders had developed service-level workflows that were effective August 1, 2024, the Director of Primary and Ambulatory Care stated they had not yet informed staff about the specific procedures, but they planned to educate them.

The Director of Primary and Ambulatory Care explained that ordering providers learn about urgent, noncritical test results through an alert notification process in the electronic health record system; and they communicate results to patients through secure messaging, telephone conversations, or certified mail if they are unable to reach them.

VHA requires facility staff to have a process for monitoring the communication of test results from ordering providers to patients.[63] The Director of Primary and Ambulatory Care stated staff monitor the test result communication process through the Ongoing Professional Practice Evaluation process but acknowledged limitations included the small sample size of electronic health records reviewed to confirm providers communicated test results to patients, and that leaders completed evaluations retrospectively, which limits opportunities to identify trends timely.[64] Facility leaders and staff said they also monitor the results of the External Peer Review Program, which includes a retrospective evaluation of test result communication data, but acknowledged sample sizes were small.

Quality management staff explained that in July 2024, they implemented an internal audit process to further monitor the communication of all test results to patients, but at the time of the site visit, the process was new, and results were not yet available. Despite concerns that staff monitor communication of test results through professional practice evaluations and external peer review processes, the OIG did not make a recommendation because staff said they recently implemented an internal audit process.

VHA also states that Emergency Department staff must not serve as the default personnel to receive after-hours (outside of typical business day) notifications of emergent and imminently life-threatening abnormal (critical) test results.[65] However, the local policy stated that Emergency Department and Urgent Care Center staff accept these test results. The Deputy Chief of Staff acknowledged being aware of the VHA requirement, but described after-hours notification of the critical results as an infrequent occurrence that did not overburden staff,

[62] VHA Directive 1088(1).

[63] VHA Directive 1088(1).

[64] Leaders use the Ongoing Professional Practice Evaluation process to monitor a licensed independent healthcare practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[65] VHA defines emergent and imminently life-threatening abnormal test result as "any new test result which must be acted upon by the VA medical facility ordering provider or their designee immediately or within a short window of time and could result in severe morbidity or mortality if left unaddressed." VHA Directive 1088(1).

adding that leaders were developing a different reporting process. The OIG recommends facility leaders review the local policy to ensure it complies with VHA directives specific to which staff receive notification of critical test results.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[66] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained. There were no open recommendations from the OIG's Comprehensive Healthcare Inspection Program report published in 2021, but the OIG had concerns about how well staff sustained action plan improvements from a prior OIG report and the facility's Joint Commission survey, as discussed in the Environment of Care domain.[67]

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.[68] 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.[69] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found quality management staff had processes for tracking patient safety concerns and monitoring improvement actions. The Patient Safety Manager and System Redesign Coordinator explained that frontline staff are engaged in the continuous learning process through quarterly patient safety forums, monthly town halls, and continuous learning forums.

The Patient Safety Manager also said patient safety staff review adverse event reports daily, and Quality and Patient Safety Council members discuss trends at quarterly meetings. The Risk Manager reported meeting with the Patient Safety Manager daily to discuss any issues or

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

[67] VA OIG, *Comprehensive Healthcare Inspection of the VA Boston Healthcare System in Massachusetts*, Report No. 21-00261-266, September 24, 2021; VA OIG, *Comprehensive Healthcare Inspection Program Review of the VA Boston Healthcare System, Massachusetts*; The Joint Commission, *Final Accreditation Report VA Boston Healthcare System*, May 23, 2024. (This report is not publicly accessible.)

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

[69] VHA Directive 1050.01(1).

concerns. The Acting Director for Quality Management stated patient safety staff brief executive leaders daily about patient safety.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[70] 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.[71] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[72] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The Supervisory Health System Specialist for Primary Care said the facility had 49 primary care teams. Primary care staff reported the following vacancies: 5 provider, 8 licensed practical nurse, and 13 medical support assistant positions. Primary care leaders described the medical support assistant and licensed practical nurse positions as the most challenging to fill. Because of the difficulty in filling positions, the Associate Chief Nurse Executive of Primary Care and Deputy Chief of Staff explained they increased the salary for medical support assistants and hired registered nurses and intermediate care technicians to fill licensed practical nurse positions.[73] The Director of Primary and Ambulatory Care and the Associate Chief Nurse Executive of Primary Care added there are float providers and nurses (staff who do not belong to a specific team) to cover for leave and vacancies.

[70] 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.

[71] 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).

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

[73] Intermediate care technicians are "military-trained medics and corpsmen who deliver health care services to Veterans." "National Center for Healthcare Advancement and Partnerships, Intermediate Care Technician," Department of Veterans Affairs, accessed December 5, 2024, https://www.va.gov/healthpartnerships/ICT.

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.[74] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[75]

The patient centered management module staff explained they review program data daily and share it with primary care leaders weekly.[76] The Supervisory Health System Specialist for Primary Care stated that in August 2024, the average panel size was at 89 percent of VHA's recommended size. Primary care staff stated that panel sizes are manageable given their current staffing.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[77] 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 staff said they are comfortable approaching leaders with ideas, and leaders encourage it and include time for staff to suggest ways to improve during their briefings each morning. Primary care leaders and staff shared an example of a process improvement initiative from their Informatics Committee, which identifies solutions to enhance the electronic health record system's efficiency and staff's ability to use it effectively. Specifically, the Director of Primary and Ambulatory Care stated the committee had worked to improve the dictation system (a method for staff to record spoken words as text in patient records), order sets (a way to organize and automate the process for placing medical orders in the system), and staff training.

The Director of Primary and Ambulatory Care shared various completed projects, including one that improved pneumonia vaccine administration rates. Patient centered management module staff also described a new shared tracking tool to identify staff assigned for leave and float coverage, with a goal to improve communication among staff.

Additionally, primary care leaders and staff stated they were proud of their patient satisfaction scores and All Employee Survey results. The Director of Primary and Ambulatory Care explained patient satisfaction with their providers was high and their service often outperformed

[74] "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).

[75] VHA Directive 1406(1).

[76] The "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." VHA Directive 1406(1).

[77] VHA Handbook 1101.10(2).

other facility departments in the survey. The Associate Chief Nurse Executive of Primary Care attributed the high scores to the implementation of HRO principles, such as daily briefings and leader rounding. Overall, primary care staff reported they felt leaders supported them in their work.

The Principal Facility Coordinator for the Patient Centered Management Module, who reported being in the role since February 2023, stated there was no formal education at the national VHA level for the coordinator role, but their supervisor had provided training.[78] The Director of Primary and Ambulatory Care expressed there were opportunities to improve training and development for patient centered management module staff. The OIG was not able to determine what type of national training is available for the principal facility coordinator for the patient centered management module position and is concerned a lack of formalized training for the role may lead to staff inconsistently using primary care data to optimize team functionality.

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 and noted the number of veterans had decreased 3.3 percent between October 2021 and January 2024. Primary care leaders attributed the decline to the decreasing numbers of veterans living in the area, although they stated the number of enrolled women veterans had increased. The OIG also reviewed appointment wait time data from FY 2023 through the first half of FY 2024 and noted that wait times for new patients had decreased from 26 to 11 days, and wait times for existing patients decreased from 11 to 9 days.

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

[78] "The principal facility coordinator (PFC) is the facility's designated staff member who manages and maintains the access, data entry, and accuracy of PCMM [Patient Centered Management Module]." VHA Directive 1406(1).

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[79]

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).[80] 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."[81]

Program staff achieved just below the 100 percent target for the HCHV5 measure in FY 2023 (98 percent) but met it for the first two quarters of FY 2024. The HCHV Outreach Team Supervisor attributed recent improvements to the walk-in clinic, which is operated by the facility's HCHV outreach team in various locations each week and staffed by social workers and other support staff to assist homeless veterans. The HCHV Program Director reported program staff conduct daily outreach to local homeless shelters and other community agencies to identify unsheltered veterans. This director further explained program staff received referrals from the National Call Center for Homeless Veterans (used by veterans who are homeless or at imminent risk of homelessness), facility consults, and the walk-in clinic, and coordinated veteran care with community partners.[82] Additionally, this director stated staff facilitate weekly veteran focus groups and work with their largest community partner, the New England Center and Home for Veterans, to provide housing and employment resources.

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

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

[81] 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.

[82] "VA Homeless Programs, National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed September 3, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

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).[83]

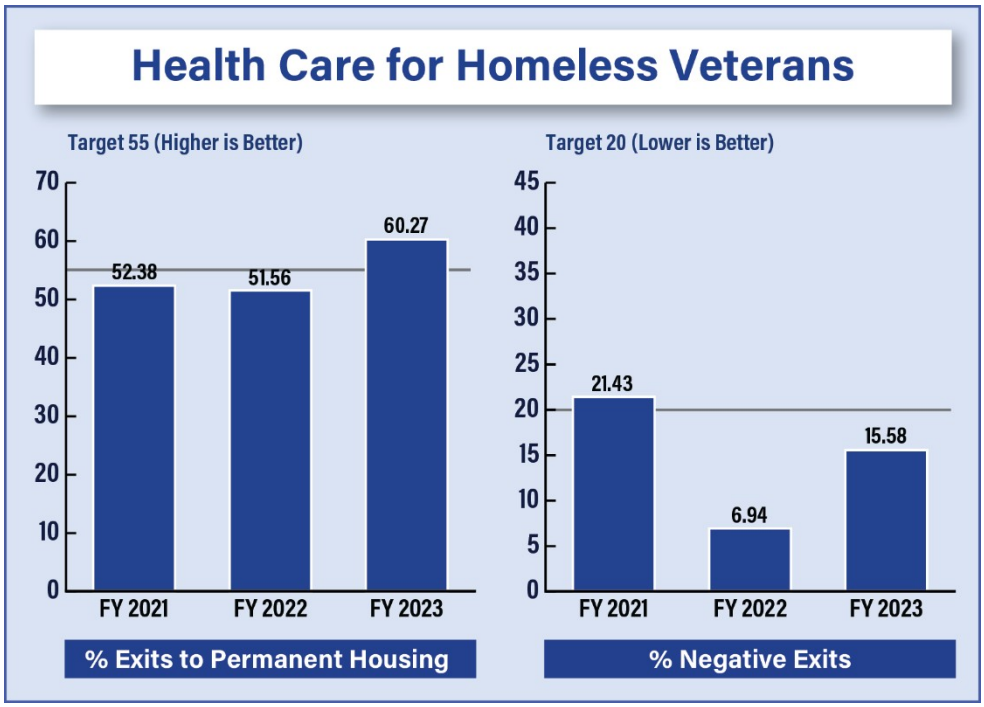

Figure 10. *HCHV program performance measures.*
Source: OIG analysis of VHA Homeless Performance Measures data.

The HCHV Program Director attributed shortfalls in meeting the HCHV1 target in FYs 2021 and 2022 to a lack of affordable housing and the limited time to find permanent housing; however, they met the target in FY 2023 due to staffing improvements. Additionally, the director credited program staff's commitment to veteran engagement for meeting the HCHV2 target in FYs 2022 and 2023, noting their coordinated exit process was another way to identify and stay connected with veterans leaving the program without permanent housing.

The director described staff collaboration with community partners to help provide temporary housing options for veterans. For example, one community program focused on identifying and tracking homeless veterans who used emergency care services more than 10 times within six months, and the HCHV team worked to facilitate medical care and housing for this population.

[83] 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*.

Another community partner dedicated 18 emergency beds to veterans for temporary shelter. However, the HCHV Outreach Team Supervisor identified challenges finding housing for older veterans living on fixed incomes who could not afford increasing rental costs; additionally, some veterans did not meet housing eligibility criteria, and some homeless shelters were at capacity.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[84] 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.[85]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[86] Program staff met the target in FY 2023 and in FY 2024 quarter two. The Veterans Justice Program Supervisor attributed this success to staff's work with many community diversion services (programs that offer alternative sentencing options that allow a defendant charged with certain crimes to avoid a criminal conviction) and collaboration with community partners. The supervisor reported when staff identify veterans who qualify for program services, program specialists have a 48-hour engagement goal to schedule an assessment. The supervisor said one way they identify veterans is by accessing information from a software program used by jails, prisons, and courts.

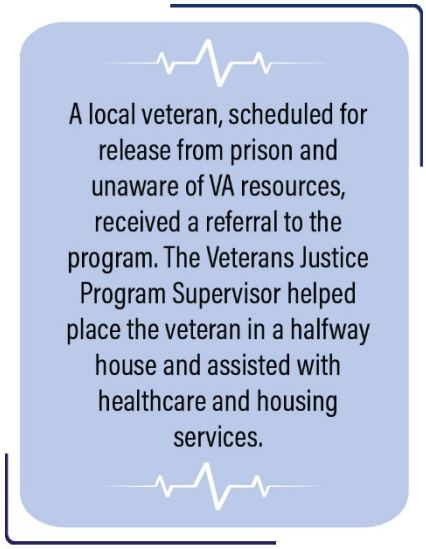

Figure 11. *Identification and enrollment into Veterans Justice Programs.*
Source: OIG interview.

The supervisor also described outreach activities with police and local mental health providers in an attempt to enroll veterans in their program as an alternative to incarceration, explaining that program staff meet with police representatives and partner with community

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

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

[86] 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*.

emergency rooms to educate them on the program and provide resources. Staff also educate the district attorney's staff on veterans treatment courts and services.[87]

Meeting Veteran Needs

The Veterans Justice Program Supervisor explained that treatment objectives varied depending on veterans' needs but may include assistance with understanding VA benefits or veterans treatment courts. Additionally, the supervisor stated that meeting veterans' needs depended on their sentencing status and veterans were more likely to have stable housing or employment prior to sentencing, so they focus on mental health stabilization and suicide prevention. For incarcerated veterans, program staff provided more intensive case management to assist with future basic needs, including housing and employment.

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."[88] 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.[89]

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).[90] From FY 2021 through FY 2024 quarter two, the facility did not meet the target. The Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager attributed this

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

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

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

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

partly to the number of veterans who applied to the program without all the required documentation, as well as occasional difficulty locating veterans during the application process.

Additionally, the manager identified several barriers to enrolling and housing veterans, such as the high cost of living in and around the Boston area, rent exceeding what the housing authority was able to pay, and veteran-specific issues, such as lack of landlord references, poor credit scores, and legal concerns that made it challenging to secure housing. The HCHV Program Director described implementing a team to focus on the voucher application process and a separate team to use vouchers to assist veterans with their housing needs.

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).[91] Program staff met the quarterly targets from April 1, 2021, through March 31, 2024. The Housing and Urban Development–Veterans Affairs Supportive Housing Program Manager attributed this success to program staff working closely with HCHV program staff to better understand individual veterans' interests and capabilities, then connecting them with employment or education.

The manager also said their multiple community partnerships were vital to meeting veterans' needs beyond just the housing vouchers. The HCHV Program Director described a collaboration with the Department of Revenue that provided guidance to veterans with child support cases and helped them return to work. The HCHV Program Director added that a planned construction project will provide 80 assisted-living housing units at the Brockton VA Medical Center.

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.

[91] 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 Response

Finding: The OIG found environment of care deficiencies similar to those reported in a May 2024 Joint Commission survey and a prior OIG review.

Recommendation 1

The OIG recommends the Director ensures staff have processes to prevent repeat environment of care findings.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

The facility has completed action plans related to this finding; however, does not consider these as repeat findings based on the established timeline for what constitutes a repeat finding. At the time of the OIG survey, the facility was monitoring environment of care issues identified by the Joint Commission survey for one month, which was not adequate to achieve sustainable change. Joint Commission surveyed May 7-10, 2024, and our action plans were developed and submitted July 7, 2024, so we had only been tracking one month of data based on the drafted actions plans at the time of the OIG visit in August. This timeline, with tracking beginning in July 2024, was not adequate to achieve sustainable change. The facility has comprehensive processes in place to address environment of care (EOC) findings and has consistently implemented a robust process for evaluating survey findings tracked through weekly EOC rounds conducted across all three campuses and community-based outpatient clinics. These EOC rounds include representatives from executive leadership, quality management, infection prevention, engineering, safety, and environmental management services and track data via performance logic. EOC rounds assess for many environmental issues such as those identified (dust on ceiling tiles and patient food refrigerators, rusty IV poles, and expired hand sanitizers. The data is subsequently reported monthly to the EOC committee, with actions tracked for follow up and reported to our VISN via the monthly management meeting. The facility also follows the VHA Directive for EOC rounding with monthly reporting, and an annual site visit from the VISN for review of all facility workspace for compliance with standards.

Additionally, the accreditation team uses the Tracer AMP tool provided by the Joint Commission and created tailored tracers specific to VA Boston. These tracers facilitate continuous evaluation of the recent Joint Commission survey data, which is reviewed by the accreditation continuous readiness committee reporting up through the quality and patient safety council (QPSC). The findings are then reported to the VISN through the monthly management meeting and to VA

Boston leadership via governing board report. Accreditation created an AMP tracer specific to the OIG findings: dusty ceiling tiles, dust on patient food refrigerator, rusty IV poles, expired hand sanitizers, hazard door signage, supply room shelves proper distance from floor, no corrugated boxes in supply rooms, bed panels are free of dust, ice machines are clean, medication rooms are locked and free of medications outside of locked areas, paper logs for temperature and humidity are checked for compliance until monitored centrally in addition to the EOC performance logic tracking, together for total number of compliant items reviewed (numerator) over total number of items reviewed (denominator) monthly for 6 months for 90% rate or higher.

Recommendation 2

The OIG recommends the Veterans Integrated Service Network 1 Director monitors for similar or repeated environment of care findings and ensures facility staff sustain improvements.

_X_ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The VISN concurs in principle, as there are multiple established processes to monitor and address recurring environment of care findings. This is evidenced by the monthly reports from the Committee of Environment of Care (CEOC) submitted by facilities to the VISN Healthcare Operations Committee, the monthly Executive Leader Group reports (referred to as STorM), the VISN Accreditation semi-annual reports presented to the Quality and Patient Safety Committee, as well as the annual VISN safety visits. In FY25 the Quality Management Officer scheduled environment of care accreditation rounds with each facility and Boston is on the schedule for a July visit. These items provide a substantial amount of oversight and future action plans include continuing these established processes.

OIG Comments

Since The Joint Commission's findings related to the environment of care persisted in several areas inspected by the OIG three months later, the OIG will monitor the action plan quarterly to ensure actions are sustained for 6 months.

Finding: The Comprehensive Environment of Care Committee failed to identify at least one environment of care trend and submit a performance improvement plan.

Recommendation 3

The OIG recommends the Veterans Integrated Service Network 1 Director ensures facility leaders identify environment of care trends and establish performance improvement plans with outcome measures to address them.

_X_ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The Veterans Integrated Service Network (VISN) 1 Director concurs with this recommendation. The VISN Healthcare Operations Committee (HOC) diligently monitors required monthly metrics from all facility-level Committees for Environment of Care (CEOC). These metrics encompass the closure of deficiencies within 14 days, participation of the Executive Leadership Team, member participation, and ensuring less than 20% miscellaneous deficiencies. Beginning in July 2025 the VISN HOC will incorporate the monitoring of facility trended performance improvement projects, along with associated action plans, into its oversight responsibilities.

Finding: Areas where staff stored biohazardous items lacked biological hazard signage.

Recommendation 4

The OIG recommends the Director ensures staff post biological hazard signs on doors where potentially infectious materials may be present.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

The identified noncompliance location was corrected during the inspection. The biological hazard signage was installed on the door (2B-115 Soiled Utility Room). The Medical Center Policy MCP 00-019-LM Occupational Exposure to Bloodborne Pathogens Exposure Control Plan was updated and changes within the policy communicated to Safety, Infection Control, Engineering, Industrial Hygienists, Emergency Management Service, and Interior Design Team. The staff were made aware of the policy change and a review of rooms for biological hazard signs is conducted at each Environment of Care EOC rounds and tracked via performance logic with action plans reported to the EOC committee; however, none have been identified since this instance. We will track EOC performance logic tracking, together with the custom AMP tracer

related to OIG findings for total number of compliant items reviewed (numerator) over total number of items reviewed (denominator) monthly for 6 months for 90% rate or higher.

Finding: Supply room shelves were not the required distance from the floor, staff stored corrugated boxes in patient care areas, ice machines were dirty, and bedframes were dusty.

Recommendation 5

The OIG recommends the Director ensures staff keep patient care areas clean and safe.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

VA Boston Environmental Management Services (EMS) supervisors conduct ongoing assessments via custom checklist that includes the above findings (supply shelves at the proper distance from the floor, ensuring no corrugated boxes are in storage areas, cleanliness of ice machines, and bedframes are free of dust, along with other items that had been identified in various observations)for standardized cleaning responsibilities across VHABHS campuses. Additionally, the Acting EMS Chief has formally requested a site visit from the Environmental Programs Service (EPS) office at VACO conducted a comprehensive review of EMS operations and procedures on June 3-5, 2025. A Retention Incentive Program has been implemented to retain skilled EMS personnel and make VA Boston EMS wages more competitive with those in the private sector.

EMS Acting Chief will submit quarterly compliance reports to the Regulatory Readiness Committee and the Quality Improvement Committee (QIC) of elements in compliance on checklist (Numerator) over total items on checklist (Denominator) monthly for 90% compliance over 6 months to ensure sustained visibility and accountability of corrective actions and performance metrics.

Finding: Unauthorized personnel had access to medication.

Recommendation 6

The OIG recommends the Director ensures only authorized staff have access to medication storage areas.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

The noncompliance was corrected during the inspection by the Quality Management Director of Medicine. The following action plan was taken to ensure compliance: badge access to Medication Room was modified with access to only authorized staff (e.g. Registered Nurses (RN) and Licensed Independent Practitioners (LIP). VA Boston Police will run the badge access report monthly to validate access and report findings to the accreditation team quarterly at the readiness committee reporting quarterly. Additionally, medications are kept in medication cabinets, which each has a different key to open. During EOC rounds, Patient Safety will ensure that all medication carts are locked and functioning properly. In the event any further deficiencies are identified, Patient Safety will report directly to the Chief of Dermatology and the Quality Management Director of Medicine. Non-compliance will be tracked in Performance Logic and reported to Environmental of Care Committee. Pharmacy will share a list of all medication storage areas and in each EOC rounds the patient safety representative will tally the number of areas compliant (Numerator) over the total number of areas observed (Denominator) and report to the accreditation team monthly for 6 months for 90% compliance.

Finding: Staff stored medications in an unapproved location; staff did not consistently monitor temperature and humidity in medication storage areas; staff did not store medications safely; and pharmacy staff inspections missed these deficiencies.

Recommendation 7

The OIG recommends the Director ensures staff conduct an inventory of all the facility's medication storage areas, and the Chief of Pharmacy approves them.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

The Pharmacy Chief, Acting Associate, and Supervisor physically reviews all clinic storage areas monthly, and the last reviews were completed: at our Jamaica Plain Clinics on May 28, 2025, for West Roxbury medication areas on June 03, 2025, and for Brockton medication storage areas on June 06, 2025. Education was provided via tiered huddles with pharmacy technicians and nursing staff that only approved, dedicated locations can be used for storage of medications. Education was also provided indicating that medication cannot be removed from dedicated storage areas. Random checks of areas are conducted by Pharmacy Supervisor and any findings presented on High Reliable Organization (HRO) Tier 2 Safety huddle as a Situation, Background, Assessment, and Recommendation (SBAR), any trends identified would be elevated to Tier 3 Safety Huddle for actions; however there have not been

any identified via rounds, post education. The Pharmacy Chief also conducts random checks of medication storage areas at least quarterly. Annual review of clinic and ward stock initiated in April 2025 by the new Pharmacy Supervisor who is systematically reviewing stock and pars in each area and obtaining Chief of Pharmacy review and concurrence for all ward/clinic stock list updates. Pharmacy leadership will provide quarterly updates to the readiness committee via the accreditation team for report of audits conducted, the number of medication storage areas in compliance (Numerator) over the number of areas audited (Denominator) for 90% compliance for 6 months.

Recommendation 8

The OIG recommends the Chief of Pharmacy ensures pharmacy staff inspect each approved medication storage area monthly.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

Pharmacy ward and clinic inspections occur monthly. A formal report out on monthly ward and clinic inspections are being added to Pharmacy Quality Management meeting for review and concurrence starting June 2025. Additional tracking on HRO Tier 2 Safety huddle will begin in June 2025 including actions for any missing ward and clinic inspections for tracking and follow-up. Pharmacy will solicit charge or nurse manager signatures on ward/clinic inspection sheets and provide a copy. Monthly Pharmacy/Nursing will begin June 24, 2025, for the Jamaica Plain campus to mirror those at other sites and Pharmacy will bring forward ward inspection findings and follow-up items to those meetings as a standing item. Pharmacy leadership will provide quarterly updates to the readiness committee via the accreditation team for report of audits conducted, which is defined as the number of medication storage areas in compliance (Numerator) over the number of areas audited (Denominator) for 90% compliance overall for 6 months.

Pharmacy will also notify the engineering team and executive leadership team (ELT) for any changes to medication storage areas and all existing approved medication storage areas for monitoring and tracking of compliance and for EOC rounds verification, should a non-approved location be used, as changes occur or annually otherwise.

Recommendation 9

The OIG recommends the Director ensures staff monitor temperature and humidity in medication storage areas and track possible deviations, even those that may occur when the areas are closed.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

Temperature and humidity for medication refrigerators is monitored centrally via Centrak; however, the ambient room temperature and humidity for medication storage areas is monitored via a department paper log. VA Boston is transitioning from paper log to centrally monitored room temperature and humidity monitoring also via Centrak beginning in July 2025. We are on contingency process with the paper logs, and currently working through a plan for areas that are monitored via these ambient sensors to come off contingency and be added for central monitoring. Pharmacy and Healthcare Technology Management (HTM) are working through the approved medication storage area list (provided for EOC rounds compliance assessment for recommendations 8 & 9) to ensure all areas are moved to this centrally monitored process.

Pharmacy is working with HTM to install and activate Centrak ambient temperature and humidity sensors for monitoring during weekend, holiday, evening, and night (WHEN) hours with a target date for completion 07/31/2025. Until roll out to centrally monitored room temperature and humidity is completed, pharmacy will conduct monthly audits (June 2025 and July 2025) for the temperature and humidity paper logs in the medication storage rooms; based on their list of approved medication storage areas; number of compliant logs (numerator) over total number of areas reviewed (Denominator) and reported to accreditation team through the readiness committee for at least 6 total months of compliance at greater than 90% with sustained tracking through monthly reporting at the readiness committee, quarterly to QPSC and annually to governing board. Nursing monitors temperature and humidity for medication storage areas in clinic and wards during all hours. AOD responds after hours. Engineering monitors via American Energy Management System (AEM) and shares the report monthly with accreditation team. A list of all medication storage areas is maintained through the Pharmacy department and shared with the accreditation (quality management) team.

Finding: The Brockton VA Medical Center's Urgent Care Center did not have a current approved waiver to operate 24 hours per day, seven days a week, or to allow its staff to respond to emergencies elsewhere on the medical center site while leaving the Urgent Care Center without a practitioner.

Recommendation 10

The OIG recommends the Director ensures the Brockton VA Medical Center's Urgent Care Center operates according to VHA Directive 1101.13 and obtains an appropriate waiver from the VHA National Program Office of Emergency Medicine as applicable.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

A waiver, Brockton Waiver for Urgent Care Directive 1101.13 was sought and approved on 12/23/2024 at 2:55:13pm by the National Emergency Medicine Office (NEMO), policy owner approving official; Neil Patel (NEMO). Prior to approval of the waiver, NEMO met with ELT and emergency services leadership as well as conducted a site visit to validate the proposed mitigation included in the waiver was in place.

This waiver expires 3/31/2028. The waiver lives in our VA Boston document SharePoint site under "Administrative Documents" that allows for notification of pending expiration 3 months prior to the expiration for timely renewal, upon review of related documents such as VHA Directive 1101.13 VHA Urgent Care. The original waiver had expired and the process of placing this waiver in our document center ensures notification to renew in a timely manner goes out to stakeholders three months prior to expiration date to mitigate concern of expiration prior to review.

OIG Comments

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

Finding: Despite VHA's expectation that emergency departments must not be the default location to receive after-hours notification of new emergent and imminently life-threatening test results, the facility's local policy identified Emergency Department and Urgent Care Center staff to receive this communication.

Recommendation 11

The OIG recommends facility leaders review the local policy to ensure it complies with VHA directives specific to which staff receive notification of critical test results.

_X_ Concur

____ Nonconcur

Target date for completion: December 30, 2025

Director Comments

VA Boston is compliant with the established timeframe for provider notification of critical results. The observed non-compliance with the directive is the party who is notified of the results

in the weekend, holiday, evening, and night (WHEN) hours being the emergency department/urgent care, which the directive prohibits. VA Boston is evaluating the following three options for who best to manage these results: the VISN wide call center of advanced practice nurse practitioners (APRN)'s and physician assistants (PA)'s, medicine/nocturnists/attending physician, or VA Boston Primary Care physicians. All potential parties have some challenges, first being that the VISN wide call center group does not report to VA Boston and thus we cannot solely deem them the right party for this work; and the physician groups identified as options are often commuting home from their day when these calls are most likely to occur which could impact timeliness of access to the patient record and notification of the veteran. VA Boston has assessed our volume of these calls with 10 such occurrences in the past 90 days. Our current system is safe and meeting the timelines established, as the intent of the Directive.

Considering the operational impact, VA Boston requests a six-months timeframe to allow a safe and sustainable transition, with a target date for competition by November 21, 2025. Once finalized, the SOP will be updated and reviewed for concurrence with stakeholders for compliance with the Directive.

Upon initiation of the new process, the Associate Director for Quality will conduct an audit of compliance with the Directive for timeliness of notification and notification via the determined party, of 100% of WHEN hour critical test results per month over 6 months. for 90 % compliance and report results to the readiness committee quarterly.

Appendix A: Methodology

Inspection Processes

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

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

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

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from August 6 through 8, 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.

[2] The OIG sent questionnaires to multiple VSO representatives provided by the facility.

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2025

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

Subj: Healthcare Facility Inspection of the VA Boston Healthcare System in Massachusetts

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

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

1. Thank you for the opportunity to review and comment on the draft report regarding the healthcare inspection report at the VA Boston 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 OIG review and corresponding report and narrative raises a significant process concern. It appears that the OIG utilizes a system to review the environment of care at VA sites that is inconsistent with industry standards. For example, The Joint Commission utilizes the SAFER Matrix system to quantify the relative risk and importance of environment of care findings. Unlike The Joint Commission, the OIG does not quantify findings based on relative risk. Instead, the OIG includes only a narrative of observations. The VA Boston Healthcare System encompasses three primary campuses, collectively covering more than two million square feet of space. The average age of buildings on each campus is well over 60 years old. Given the extensive size and the age of these facilities, singular observations such as a stained ceiling tile or dust on a refrigerator do not necessarily indicate a system-wide concern of cleanliness, an improper system to inspect such spaces, or a lack of VISN oversight of facility EOC inspection processes. The VA Boston Healthcare System has a robust environment of care rounding process to identify and immediately correct low risk issues such as these. To imply that any system can perfectly eliminate any chance of such findings is impractical and inconsistent with industry standards. The facility has systems in place, including required monthly environment of care rounding, site visits, and quality reviews, which the VISN does monitor.

4. The leadership teams at the VA Boston Healthcare System and VISN 1 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: May 23, 2025

From: Vincent Ng, Medical Center Director, VA Boston Healthcare System (523)

Subj: Healthcare Facility Inspection of the VA Boston Healthcare System in Massachusetts

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

1. VA Boston Healthcare System received the VA OIG Draft Report entitled "Healthcare Facility Inspection of the VA Boston Healthcare System in Massachusetts" on May 13, 2025.
2. Director's Comments in response to the OIG's recommendations are attached to this memo.

(Original signed by:)

Vincent Ng
Medical Center Director
VA Boston Healthcare System

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