US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA White River Junction Healthcare System in Vermont

Healthcare Facility Inspection	26-00084-274	September 23, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA White River Junction Healthcare System (the facility) from March 17 through 24, 2026. The facility is rated as *medium complexity* and in fiscal year 2025, provided direct care to 25,661 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team observed that some crosswalks lacked detectable warning surfaces, a safety feature for those with visual impairments. VA's *PG-18-10, Site Design Manual* requires facilities to install these surfaces "anywhere a walkway transitions into a vehicle roadway."[3] The OIG made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of

[1] VHA classifies facilities based on their complexity level. Medium-complexity facilities have "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 through March," VHA Support Service Center, last updated April 7, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

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

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

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

homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director installs detectable warning surfaces at all walkways that transition to roadways, in accordance with VA's *PG-18-10*, *Site Design Manual*.

VA Comments and OIG Response

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

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

Abbreviations

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

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Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[6] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

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

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

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

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

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

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

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

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

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

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

The VA White River Junction Healthcare System (the facility) opened in 1938. It includes the White River Junction VA Medical Center (the medical center) and seven community-based outpatient clinics in Vermont and New Hampshire.[11] The facility maintains 38 hospital and 14 domiciliary beds.[12] In fiscal year (FY) 2025, its medical care budget was approximately $458 million.[13]

The OIG team inspected the facility from March 17 through 24, 2026. The executive leaders referred to throughout this report include the Executive Director, Acting Associate Director, Associate Director for Patient Care Services, and Chief of Staff.

Figure 1. *Facility photo.*
Source: "White River Junction VA Medical Center," VA, last updated May 4, 2026, https://www.va.gov/white-river-junction-health-care.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[14] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[15] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[16]

[11] VA temporarily closed the Brattleboro community-based outpatient clinic for building repairs at the time of inspection.

[12] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/homeless/dchv.

[13] "Trip Pack - Operational Statistics Table FY2026 Through March," VHA Support Service Center, last updated April 7, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

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

[15] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

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

System Shocks

The executive leaders and the chief of quality and patient safety reported that a May 2025 flood—caused by heavy rainfall that overwhelmed the facility's drainage system—forced changes in clinical operations and disrupted patient care until January 2026. The flooding occurred on a Saturday evening, primarily in the emergency department, and prompted the relocation of the department and all patients to another building. The Executive Director and Acting Associate Director said the alternate building had clinical space previously used during the COVID-19 pandemic, which allowed executive leaders to minimize disruptions to patients during the recovery.

For the first week after the flooding, the Acting Associate Director and Associate Director for Patient Care Services said executive leaders set up an incident command center (a standardized organizational structure to manage operations during an emergency).[17] Executive leaders and the facility's emergency manager used the center to communicate initial updates to veterans through news releases, email, and social media, and to employees through text messages and phone calls.[18]

After reviewing the event, the Acting Associate Director identified several ways to improve processes. These included annual updates to each service's emergency plan; the purchase of large dehumidifiers; a quarterly requirement for service leaders to review and update employee contact information; and the creation of Standard Operating Procedure, *Facility Water Leak/Intrusion Response*.[19] The Acting Associate Director said these actions will help strengthen the facility's response to future floods. The Acting Associate Director and the Associate Director for Patient Care Services credited the facility emergency manager's coordination and communication skills, along with employees' resilience, as key factors in the ability to mitigate adverse effects from the event.

Employee Experiences

Responses to the OIG questionnaire showed that about 45 percent of employees agreed or strongly agreed the facility's culture was moving in the right direction, and about 60 percent agreed or strongly agreed they were comfortable suggesting actions to improve their work environment, as shown in figure 2. The Executive Director, Acting Associate Director, and Chief of Staff attributed these responses to their emphasis on requesting employee feedback, providing

[17] VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

[18] WCAX News Team, "White River Junction VA Medical Center ER Temporarily Relocates," *WCAX*, May 18, 2025, updated May 19, 2025, https://www.wcax.com/2025/05/19/white-river-junction-va-medical-center; VA, "White River Junction VA Emergency Department Returns to Mountains Building Location," press release, January 9, 2026, https://www.va.gov/white-river-junction-health-care/news-releases.

[19] VA White River Junction Healthcare System, "Facility Water Leak/Intrusion Response" (standard operating procedure), March 2, 2026.

informal avenues for communication, and promoting civility in workplace interactions. Their efforts included

- a form on the facility's intranet page that employees use to submit questions directly to the Executive Director,
- a monthly forum with time for all employees to ask executive leaders questions, and
- facility-wide presentations that emphasize civility in daily interactions.

Most questionnaire respondents indicated that leaders' communications were clear, useful, and frequent. Additionally, more than half said they continued working at the facility because of job satisfaction.

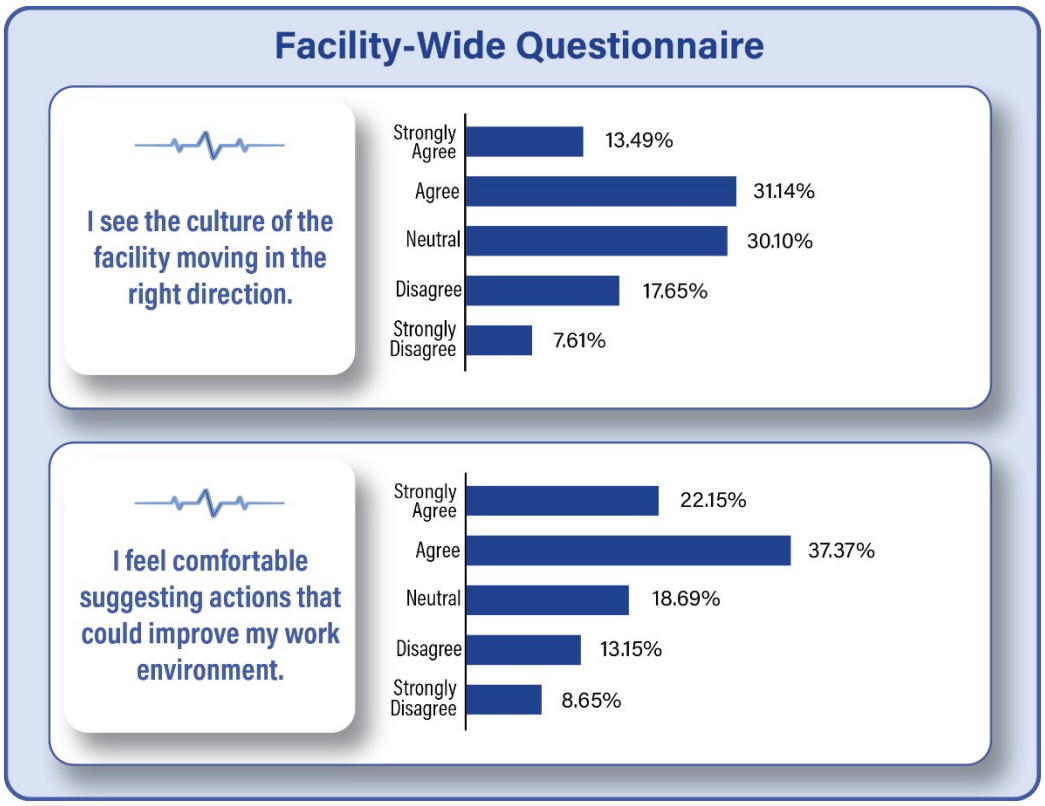

Figure 2. *Employees' perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

The facility's FY 2025 VSignals scores showed 96–97 percent of veterans trusted the facility to meet their needs for outpatient care. These scores exceeded VHA's average of 94 percent, as shown in figure 3. The OIG team noted that executive leaders shared these results with employees through weekly emails and monthly supervisor meetings that highlighted feedback and the positive effect employees had on veterans.

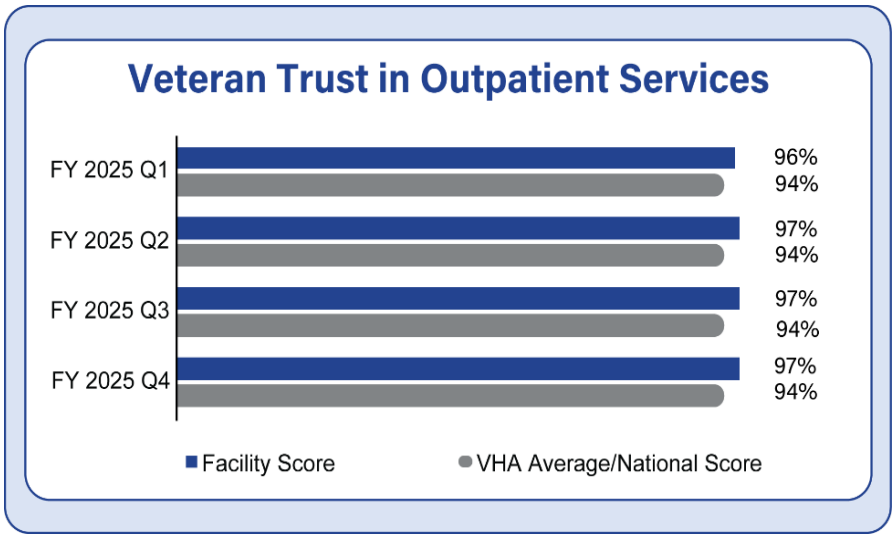

Figure 3. *Veteran trust in outpatient services.*
Source: VSignals data.

In the OIG questionnaire, a patient advocate reported that veterans often complained about reaching an off-site call center rather than facility staff when calling. The call center operates at the Veterans Integrated Service Network (VISN) level, and the Executive Director acknowledged the challenges.[20] The Associate Director for Patient Care Services described working with call center leaders to improve routing and, to ensure veterans' needs are met, the facility's primary care nurses contact each veteran within one business day after a call center interaction.

The facility offered two examples of initiatives to improve veterans' experience and health. According to the Acting Associate Director, a new color-coded transportation card helped veterans make it to appointments on time. The coding allowed drivers to easily identify which transportation service was responsible for picking up and dropping off the veteran, which resulted in reduced transportation delays. Executive leaders also described a unique program that provided veterans with access to fresh produce from local farms. The goal was to improve the overall health of veterans through changes in diet. An evaluation sent by the program's leaders

[20] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

found 95 percent of veterans enrolled in the produce program reported they now eat more fresh vegetables.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[21] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

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

General Inspection

At the medical center, the OIG team found clear parking signs, and the parking lots had police patrols and ample spaces, including accessible spots for individuals with mobility limitations. The facility also had a public transit stop and shuttles to take veterans to and from parking lots and the main entrance.

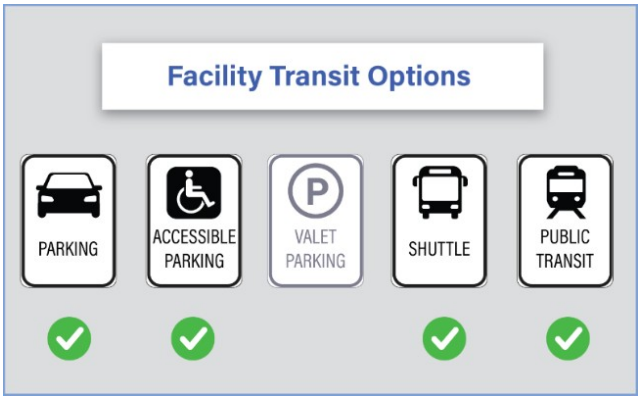

Figure 4. *Transit options for arriving at the facility. Source: OIG observation.*

The main entrance drop-off area had an overhead canopy to protect veterans from the weather. However, the team found there were no detectable warning surfaces at some crosswalks. These surfaces serve as a safety feature to alert individuals with visual impairment of approaching roadways, and VA's *PG-18-10*, *Site Design Manual* states facilities must install them "anywhere a walkway transitions into a vehicle roadway."[23] Facility leaders were unaware of the lack of detectable warning surfaces and the requirement.

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

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

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

Recommendation 1

The Director installs detectable warning surfaces at all walkways that transition to roadways, in accordance with VA's *PG-18-10, Site Design Manual.*

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2027

Director Comments

A comprehensive inspection of the campus was completed to identify walkways with transitions to roadways requiring installation of detectable warning surfaces. Facilities Management will conduct a market assessment of safety products with attention to weather specific conditions faced at this medical center. Facilities Management will submit a contracting package in alignment with design guidance from VA's PG-18-10, Site Design Manual, revised March 1, 2024, and manage the contract through project completion. Temporary safety measures will include the use of high visibility paint, cones, and signage at locations identified as high risk (e.g., front entrance). Ongoing oversight and responsibility rest with the Chief of Facilities Management.

Figure 5. *Accessibility tools available to veterans with impairments.*
Source: OIG observations and the facility liaison's questionnaire response.

The lobby was well lit and had ample seating, wheelchairs, and reading materials. The OIG team observed color-coded maps with large pictures posted near the reception desk and in elevators, and printed copies were available. The facility also provides closed-captioned televisions, translation services, braille on signs and in elevators, and, on request, assistive listening devices.

The team inspected several patient care areas, including the emergency department, primary care clinic, and medical-surgical unit. Inspectors observed clear exit paths, undamaged furniture, and no privacy violations.

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

Communication of Urgent but Noncritical Test Results

The inspection team found that facility staff established and followed processes that align with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* for

- notification of urgent, noncritical test results to providers;
- follow-up with patients;
- assignment of an alternate provider when the provider who ordered the test is unavailable or has left the facility; and
- transmission of results outside regular clinic hours and during care transitions.[24]

Action Plans and Process Improvements

The team did not identify any findings from the prior OIG inspection that were related to test result communications, or recommendations that remained open (unimplemented) for more than a year.[25] In an interview, facility staff explained that improvement efforts usually begin with action plans developed in response to oversight recommendations. The facility's regulatory readiness group then tracks compliance until each action plan is completed and closed.

When inspectors asked for an example of an improvement project, staff described how they reduced the number of daily notifications in the electronic health record system (view alerts) a provider receives by turning off duplicative alerts to make sure the alerts that require follow-up and review are prioritized. Per VHA Directive 1088(1), facility staff must review the number and type of notifications providers receive and use them only when necessary to avoid creating extra work.

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

[25] VA OIG, *Comprehensive Healthcare Inspection of the White River Junction VA Medical Center in Vermont*, Report Number 23-00015-86, February 28, 2024.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[26] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

At the time of the inspection in March 2026, the principal facility coordinator for primary care reported that 46 teams delivered primary care at the facility, and vacancies included registered nurses, licensed practical nurses, medical support assistants, and a clinical pharmacist. The primary care staffing ratios in January 2026 were below the guidelines in VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* (three full-time equivalent support staff for each provider).[27] Primary care leaders said the most difficult positions to fill are provider roles at the rural community-based outpatient clinics and licensed practical nurse positions across the healthcare system.

The chief nurse of primary care reported maintaining open, continuous announcements for licensed practical nurse positions for six months prior to the inspection in March 2026 and converting some roles to registered nurse positions to attract more applicants. Also, leaders use the Clinical Resource Hub (a VISN program that provides support to increase access to VHA clinical services for veterans when local facilities have gaps in care) and surrogate providers (who provide clinical coverage for absent providers) to ensure veterans' access to care.[28]

In 2025, the average new patient appointment wait time was less than 20 days (the Code of Federal Regulations, title 38, section 17.4040 states that patients may be referred to community providers if the wait time is longer than 20 days).[29] The principal facility coordinator and the acting chief of primary care attributed the wait times to new patient coordinators who help contact patients, obtain outside medical records, promptly schedule appointments, and ensure

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

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

[28] "Clinical Resource Hubs (CRH)," VA, accessed March 26, 2025, https://www.patientcare.va.gov/crh.

[29] 38 C.F.R. § 17.4040 (2025).

patients are prepared for initial visits. Additionally, these staff members enhance access by regularly reviewing wait times and related metrics with leaders.

The principal facility coordinator for primary care reported monitoring panel sizes—the number of patients assigned to each care team—and reassigning patients to ensure an equitable distribution of workload across primary care teams. At the time of the inspection in March 2026, the principal facility coordinator for primary care reported that 13 of 46 teams exceeded the panel capacity (an adjustable number based on staff support, examination rooms, patients' conditions, number of female veterans, and provider type) outlined in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* due to staff vacancies.[30] However, the acting chief of primary care stated that the vacancies did not adversely affect patients' access to primary care.

The acting chief and chief nurse of primary care explained they hold routine staff meetings to keep staff involved and gather ideas and feedback to improve operations. Additionally, they maintain active involvement with the acute care walk-in clinic to meet patients' needs and provide telehealth coverage to reach patients in rural areas. Further, the primary care registered nurse and advanced medical support assistant contributed to a colon cancer screening initiative that, from October to December 2025, achieved a 54 percent increase in patients' returning home screening kits to the facility for testing. They improved the rates through monthly monitoring of returned kits, contacting patients whose kits had not been received, and sending letters with information about the importance of screening along with new kits.

Community Care Staffing and Access to Care

The associate chief/nurse manager of community care reported three clinical and two administrative staff vacancies at the time of the inspection in March 2026, which were due to retirements, transfers, and the return-to-office mandate.[31] The director of integrated veteran care said three positions were in active recruitment, and community care leaders would participate in the medical center's upcoming job fair to attract candidates. The associate chief/nurse manager of community care added that a recent special salary adjustment for medical support assistants helped attract candidates.

To manage workload, the associate chief/nurse manager of community care said staff voluntarily work overtime. They also reported several process improvements to reduce referral processing times, including an automated referral tracking system that shows information in real time and implementing a contract for printing documents.

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

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

In FY 2025, most referrals were for imaging and dental services. Facility staff referred patients to community providers because of long drive times, services unavailable at the facility, and continuity of care with established community providers.

Additionally, the associate chief/nurse manager of community care and director of integrated veteran care said the VA White River Junction Healthcare System is the only VHA facility in the continental United States without on-site dental services. They added that the VA Dentistry program approved a collaborative two-year pilot project with the facility to expand veterans' access to dental care by establishing a mobile dental clinic, anticipated to begin providing care later in the year.

As of May 2026, the OIG team found that staff took an average of 21 days to schedule community care appointments. However, VHA's *Consult Timeliness Standard Operating Procedure* requires program staff to schedule appointments within 7 days after a provider enters a referral.[32] The associate chief/nurse manager of community care and director of integrated veteran care attributed the scheduling delays to staff vacancies, a high volume of referrals, administrative requirements involved in processing them, and limited specialty care providers available in the community. The associate chief and chief nurse of primary care shared that they offer veterans the option to receive care at other VA facilities and provide community wait time information to help them decide.

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

Health Care for Homeless Veterans

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

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted

[32] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure," June 12, 2025.
[33] VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[34] HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[35] The facility's HCHV program manager reported the program did not have contracted residential services at the time of the OIG inspection in March 2026.

Performance and Improvement Highlights

- To meet the housing, medical, and mental health needs of veterans experiencing homelessness, the program manager said staff collaborated with community partners and shelters. However, the program manager stated that rural regions in the service area limit physical outreach.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[36] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[37]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[38]

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

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

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

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

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

Performance and Improvement Highlights

- The facility's program did not meet the voucher use (HMLS3) target for FY 2025 or the first two quarters of FY 2026. The program manager attributed this to staff vacancies, challenges hiring in rural locations, and the elimination of a position due to facility reorganization.
- The program had access to 45 housing units for veterans using vouchers. The acting chief of mental health stated these units have helped the program overcome the challenge of limited affordable housing.
- The program met the employment (VASH3) target for FY 2025 and the first two quarters of FY 2026. The acting chief of mental health credited this success to staff education and improved accuracy of data entered in the national database.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[39] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[40]

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target for FY 2025, and it was meeting the target as of the second quarter of FY 2026, through outreach to jails, courts, and community partners.
- The program specialist coordinates with legal, medical, and mental health providers to enroll veterans and refer them to appropriate services. Despite the recent reduction of one program position, the specialist emphasized staff's strong collaboration and outreach with justice system and law enforcement staff.

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

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

Conclusion

To assist leaders in evaluating the quality of care at the VA White River Junction Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to detectable warning surfaces on walkways. The OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[41] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from March 17 through 24, 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[42] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[43]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[44] The OIG acknowledges potential bias because the liaison for the facility selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[41] The accreditation reports covered the time frame of October 1, 2024, through September 30, 2025—the most recent available at the time of the inspection.

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

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

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[45] 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.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 24, 2026

From: Director, VISN 1 (10N1)

Subj: Healthcare Facility Inspection of the VA White River Junction Healthcare System in Vermont

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

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

(Original signed by:)

Ryan S. Lilly, MPA
Veterans Integrated Service Network 1 Director
Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 10, 2026

From: Acting Executive Director, VA White River Junction Healthcare System (405)

Subj: Healthcare Facility Inspection of the VA White River Junction Healthcare System in Vermont

To: Director, VISN 1 (10N1); Director, Health Service Area 1.1

1. I appreciate the opportunity to review and respond to the Office of Inspector General draft report, Healthcare Facility Inspection of the VA White River Junction Healthcare System in Vermont. I have reviewed the draft report and concur with Recommendation 1.
2. The VA White River Junction Healthcare System has initiated corrective action to address Recommendation 1 and will install detectable warning surfaces at all walkways that transition to roadways in accordance with VA PG-18-10*, Site Design Manual* (Revised March 1, 2024). Work is underway to determine the requirements to complete this corrective action. The target date for completion is September 30, 2027.
3. I appreciate the OIG inspection team's review and its identification of this opportunity to strengthen the safety and accessibility of our campus for Veterans and others we serve. The VA White River Junction Healthcare System is committed to fully implementing the recommendation and ensuring the corrective action is completed and appropriately documented.

(Original signed by:)

Kelley Saindon, DNP, RN, NE-BC, CHPN
Acting Executive Director

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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.