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

Office of Healthcare Inspections

## VETERANS HEALTH ADMINISTRATION

# Healthcare Facility Inspection of the VA Indiana Healthcare System in Indianapolis

| Healthcare Facility Inspection | 25-00207-36 | February 3, 2026 |
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## OUR MISSION

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

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# Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG examined the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families. The OIG continued communication with VHA regarding the findings of this inspection.

## What the OIG Found

The OIG physically inspected the VA Indiana Healthcare System (facility) from March 17 through 21, 2025.[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. Executive leaders identified significant infrastructure challenges that included water leaks, and issues with the air handler and sterile processing as system shocks.

Leaders explained that sudden staffing losses due to federal restructuring and a hiring freeze strained the supply chain department; specifically, they lacked sufficient staff to stock operating rooms and clinics with medical supplies.[2] Therefore, staff from other departments, such as human resources, helped stock supplies and minimize disruptions to patient care.

For veterans, leaders tracked satisfaction through surveys and direct outreach. When inpatient satisfaction scores fell, leaders personally called recently discharged veterans and addressed their concerns, such as clarifying post-discharge instructions.

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[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] "As part of this freeze, no Federal civilian position that is vacant at noon on January 20, 2025, may be filled, and no new position may be created except as otherwise provided for in this memorandum or other applicable law. Except as provided below, this freeze applies to all executive departments and agencies regardless of their sources of operational and programmatic funding." Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

## 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 reviewed a previous Joint Commission report and Veterans Integrated Service Network annual facility evaluation; both had findings of exit pathway obstruction in several areas at the facility.[3] In the basement hallway, the OIG found pallets of supplies and patient beds stored in the basement hallway under signs that stated storage was prohibited. The acting Chief Supply Chain Officer explained the receiving room was not large enough to store incoming shipments. The Chief of Healthcare Technology Management reported that some beds in the hallway were awaiting repair, and others were awaiting redistribution after cleaning.

Additionally, a 2024 OIG Comprehensive Healthcare Inspection Program report included a recommendation that the Associate Director ensures managers maintain a safe and clean environment throughout the facility.[4] However, the OIG observed multiple cleanliness issues: in the Emergency Department, a new patient walker and cleaning supplies were in the soiled utility room and corrugated boxes in the clean storage room; on the Medical-Surgical Unit, air ventilation grills and the top of an automated medication dispensing cabinet were dusty; unused supplies and debris were on the floor of a clean supply room; and walls in a patient room had chipped paint, residue, and damage.[5] The OIG made a recommendation.

To address it, the Director said Quality Management Service staff educated clinical leaders on infection prevention and reusable equipment cleaning and storage, and leaders granted Environment Management Service staff entry to locked storage areas to perform daily cleaning. Staff will review inpatient rooms for issues such as damaged walls, report them for timely repair, and inspect the environment monthly until they achieve sustained compliance (see OIG Recommendations and VA Responses).

The OIG also found a tripping hazard from a raised flexible joint between two concrete sections near the Emergency Department's entrance. The facility had placed four traffic cones to redirect

[3] 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/.

[4] VA OIG, *Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*, Report No. 22-03165-46, January 3, 2024.

[5] Corrugated boxes are an infection control concern because they "are susceptible to moisture, water, vermin and bacteria during warehouse or storeroom storage, as well as transportation environments. Boxes and containers may have been exposed to unknown and potentially high microbial contamination." "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed August 4, 2025, https://www.jointcommission.org/support-center/standards-faqs.

pedestrian traffic, which engineering staff removed and replaced with permanent guard rails after discussion with the OIG. The Chief of Engineering reported plans to fix the flexible joint as part of an approved repair project.

Additionally, the OIG observed mixed soiled and clean patient equipment in the clean storage area of the Medical-Surgical Unit, Emergency Department, and the Blue Clinic (a primary care clinic) hallway. The OIG recognized leaders' efforts to address the issue and therefore did not make a recommendation.

## Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined that facility staff had processes to communicate urgent, noncritical test results to providers and patients that were compliant with VHA's updated directive.[6] Quality Management staff used patient safety reports to identify areas that need improvement and worked with the Systems Redesign team to initiate projects based on trends. In addition, executive leaders attended staff meetings to communicate opportunities for improvement. Recognition awards, such as the Great Investigators and Great Catch awards, identified staff who captured why patient safety events happened and those who reported events that could have caused harm so leaders could implement prevention measures.

## Primary Care

The OIG determined whether primary care teams were staffed according to 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 affected primary care delivery structure and new patient appointment wait times.[7] Veteran enrollment at the facility increased due to the PACT Act, but primary care leaders said it had not affected efficiency.

The OIG found primary care had multiple vacancies that included providers, nurses, and medical support assistants. To address this concern, leaders stated they used the Veterans Integrated Service Network's Clinical Resource Hub to assist providers.[8] The OIG found that appointment wait times for new patients were between 20 and 25 days, which is above VHA's recommended

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

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

[8] Clinical Resource Hubs are "programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed February 10, 2025, https://www.patientcare.va.gov/primarycare/CRH.asp.

20-day standard. The Director attributed the wait times, in part, to veterans' requesting specific dates that may have prolonged their wait.

Primary care staff said patients were previously scheduled for their laboratory appointments prior to their clinic appointment to allow providers to have the results available to discuss at the appointment; however, a recent change in patient laboratory scheduling procedures no longer allowed staff to schedule patients before the clinic appointment, which could potentially delay care. Staff members expressed concerns about this change and its negative effect on workflow efficiency. The OIG made a recommendation for leaders to review clinic efficiency. In response, the Director said leaders and Primary Care Service staff revised patient instructions on appointment reminder postcards, letters, and text messages to ensure patients complete needed tests before primary care visits. Quality, Safety, and Value staff will monitor process changes for any patient safety concerns and until they achieve sustained compliance (see OIG Recommendations and VA Responses).

## Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans into the programs and how well the programs meet veterans' needs. The Health Care for Homeless Veterans program exceeded the target for completing program intake assessments for unsheltered veterans in fiscal year (FY) 2024. A program leader attributed this to outreach conducted by all homeless program staff, hiring additional team members, and prompt responses to referrals. Additionally, staff participated in the point-in-time count to identify unsheltered veterans and help them enroll in VA health care.[9]

The program exceeded the target for veterans discharged from transitional to permanent housing in FYs 2022 and 2023 and missed the target by less than 1 percent in FY 2024. Performance on preventing negative discharges exceeded the target in FY 2022 and met the target in FY 2023 when fewer veterans were in the program. Although enrollment increased in FY 2024, the Homeless Outreach and Community Partnerships Program Coordinator stated some veterans struggled with the rules, which resulted in their removal, thus the program missed the target that year.

The Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet targets for the percentage of housing vouchers used for FYs 2022 through 2024. While program staff did not meet the FY 2022 target percentage of employed veterans in the program,

[9] 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.

they exceeded targets in FYs 2023 and 2024. Program leaders said hiring an experienced staff member contributed to this success.

The Veterans Justice Program exceeded target numbers for enrolling veterans in FYs 2023 and 2024. The Program Manager cited the staff's visibility in the VA facility and the community as a contributing factor. Program staff provided outreach and education in jails and prisons. After identifying and assessing veterans, program staff addressed their needs through referrals to VA and community programs.

## What the OIG Recommended

The OIG made two recommendations.

1. The Assistant Director ensures staff maintain a consistently clean environment throughout the facility to prevent repeat environment of care findings.
2. Executive leaders review the change in laboratory scheduling practices and minimize its effect on clinic efficiency.

## VA Comments and OIG Response

The interim Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans, and leaders are implementing corrective actions (see OIG Recommendations and VA Responses, and appendixes C and D for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

# Abbreviations

| | |
|---|---|
| ADPCS | Associate Director, Patient Care Services |
| 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 |

# FACILITY IN CONTEXT

**VA Indiana Healthcare System**
**Indianapolis, Indiana**
Level 1a-High Complexity
Marion County
Hospital Referral Region: Indianapolis

## Description of Community

### POPULATION

| | |
|---|---|
| Female **2,024,013** | Male **1,970,662** |
| Veteran Female **22,512** | Veteran Male **212,635** |

Homeless - State **5,449**
Homeless Veteran - State **482**

### MEDIAN INCOME

**$58,849**

### EDUCATION

**89%** Completed High School
**56%** Some College

### VIOLENT CRIME

Reported Offenses per 100,000 **132**

### SUBSTANCE USE

**17.1%** Driving Deaths Involving Alcohol
**18.0%** Excessive Drinking
**1,716** Drug Overdose Deaths

### UNEMPLOYMENT RATE

**3%** Unemployed Rate 16+
**4%** Veterans Unemployed in Civilian Workforce

### TRANSPORTATION

| | |
|---|---|
| Drive Alone | 1,519,895 |
| Carpool | 166,229 |
| Work at Home | 114,941 |
| Walk to Work | 43,696 |
| Other Means | 23,473 |
| Public Transportation | 15,229 |

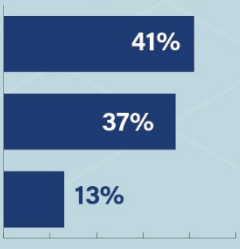
### AVERAGE DRIVE TO CLOSEST VA

| | |
|---|---|
| Primary Care | **28 Minutes, 24 Miles** |
| Specialty Care | **51 Minutes, 47 Miles** |
| Tertiary Care | **76 Minutes, 71 Miles** |

## Access to Health Care

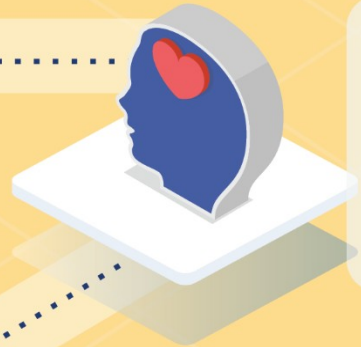
### ACCESS

VA Medical Center Telehealth Patients **20,771**



# Health of the Veteran Population

**336** VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

**16,426**

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

**5.07** Days

30-DAY READMISSION RATE

**11%**

## SUICIDE RATE PER 100,000

| Suicide Rate (state level) | Veteran Suicide Rate (state level) |
|---|---|
| 21 | 35 |

# Health of the Facility

## UNIQUE PATIENTS

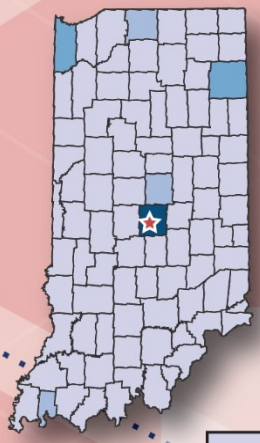
| | |
|---|---|
| Unique Patients VA and Non-VA Care | 63K |
| Unique Patients VA Care | 61K |
| Unique Patients Non-VA Care | 22K |

## COMMUNITY CARE COSTS

| | |
|---|---|
| Unique Patient $26,999 | Outpatient Visit $307 |
| Line Item $1,338 | Bed Day of Care $324 |

## STAFF RETENTION

| | |
|---|---|
| Onboard Employees Stay <1 Yr | 11.35% |
| Facility Total Loss Rate | 12.16% |
| Facility Retire Rate | 1.79% |
| Facility Quit Rate | 8.96% |
| Facility Termination Rate | 1.32% |



★ VA MEDICAL CENTER

VETERAN POPULATION

0.11% 2.78% 5.45% 8.11% 10.78% 13.43%

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) 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 cyclical review program to help accomplish its mission. Inspection 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 (VA), "VHA's Journey to High Reliability."*

Healthcare Facility Inspection 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 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.

## 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 (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), 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).

# Content Domains


***Figure 3.*** *Healthcare Facility Inspection'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(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.*

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

The VA Indiana Healthcare System (facility), the first general medical and surgical VA hospital in the state, has served veterans since 1932. The facility had 209 operating beds, which included 159 hospital and 50 domiciliary beds, and a fiscal year (FY) 2023 medical care budget of approximately $933 million.[13]

The OIG inspected the facility from March 17 through 21, 2025. The facility's executive leaders consisted of the Medical Center Director (Director); Associate Medical Center Director (Associate Director); Chief of Staff; Associate Director, Patient Care Services (ADPCS); and interim Assistant Director. The Director was selected in September 2022; the Associate Director and Chief of Staff were appointed in January 2024 and January 2025, respectively; the ADPCS had served in the role since September 2018; and the interim Assistant Director was assigned in November 2024.


A 2018 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[16]

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed September 29, 2025, https://www.va.gov/homeless/dchv.asp.

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

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

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

## System Shocks

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

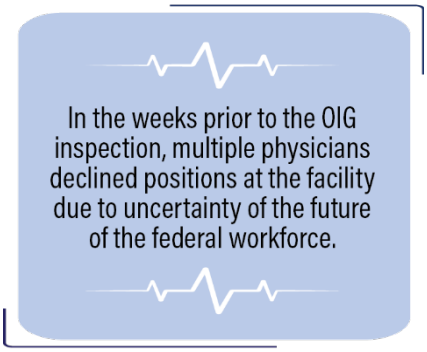



***Figure 4.*** *System shocks.*
*Source: OIG interview.*

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In an interview, executive leaders described infrastructure issues and the sudden federal government restructuring as system shocks.

The Associate Director discussed multiple infrastructure issues throughout the aging facility, such as water leaks and air circulation problems. The OIG noted multiple patient care rooms in the intensive care unit were shut down due to rainwater damage over the prior weekend, and staff relocated patient care rooms to another area. The Chief of Engineering explained that executive leaders approved emergency funding for a repair project for the intensive care unit but were awaiting a proposal from a contractor.

Leaders told the OIG that infrastructure challenges delayed care. For example, staff rescheduled patients' surgeries because the air circulation equipment shut down and affected temperature and humidity in operating rooms. The ADPCS said staff monitored every patient who had their surgery rescheduled and none experienced harm. The Associate Director told the OIG there were pending projects to replace the air circulation unit and upgrade the electrical system, but neither had received funding.

The executive leaders also described infrastructure problems with the sterile processing service. In 2024, leaders closed the service for about three months due to poor steam quality that affected the sterilization process, then closed it again for one week in 2025 because of a water leak.[19] The Associate Director said the closures initially reduced operating room capacity; however, through coordination with staff at other facilities to sterilize operating room instruments, full operations

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

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

[19] Sterile processing staff "clean, inspect, test, sterilize, store and deliver devices" used in health care, such as dental clinics, surgeries, and other medical settings. "What Is Sterile Processing," Healthcare Sterile Processing Association, accessed April 8, 2025, https://myhspa.org/about/what-is-sterile-processing/.

promptly resumed. The ADPCS informed the OIG that no adverse patient events occurred due to these incidents, and the Associate Director said Veterans Integrated Service Network (VISN) leaders approved a project for FY 2026 to permanently fix the steam quality issue.[20]

Executive leaders discussed the effects of staffing changes on facility operations. Specifically, the current hiring freeze, which prevented hiring of technicians who supply operating rooms and clinics, and the firing of six probationary supply chain staff exacerbated long-standing staffing issues in the supply chain department.[21] According to the acting supply chain chief, the VA Chief Human Capital Officer terminated probationary staff in late February 2025, via email without prior knowledge of VISN or facility leaders.

Leaders and staff found ways to ensure medical supplies remained stocked. For example, several human resources specialists and a program analyst received on-the-job training and began stocking supplies to ensure operating rooms and clinics could operate without disruption to patient care. The acting supply chain chief told the OIG that VHA reinstated three probationary staff about one month later, and then three others.

The Director shared concerns about future staffing needs because the facility had about 150 doctors and nurses eligible for early retirement. Furthermore, the Associate Director emphasized challenges in anticipating staffing changes because information about VHA's plans for a reduction in force and reoffering deferred resignation or voluntary early retirement programs were unknown in March 2025.[22]

The Director stated that staff have been in a state of shock due to the uncertainty of changes across the federal government. The ADPCS said staff asked executive leaders for information, and in response, leaders met with them multiple times to discuss the changes and their potential impact on the facility. The Director added that staff volunteered for additional work, which showed resilience and dedication to veterans' care.

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[20] 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 July 2, 2025, https://department.va.gov/integrated-service-networks/.

[21] "As part of this freeze, no Federal civilian position that is vacant at noon on January 20, 2025, may be filled, and no new position may be created except as otherwise provided for in this memorandum or other applicable law. Except as provided below, this freeze applies to all executive departments and agencies regardless of their sources of operational and programmatic funding." Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

[22] "In the Federal Government, layoffs are called reduction in force (RIF) actions." "Reductions in Force (RIF)," Office of Personnel Management, accessed October 2, 2025, https://www.opm.gov/reductions-in-force-rif. The deferred resignation program is a choice to depart federal government positions retaining pay and benefits with an exemption of the return to in-person work requirements until September 30, 2025. "Original Email to Employees, Deferred Resignation Email to Federal Employees," Office of Personnel Management, accessed October 7, 2025, https://www.opm.gov/fork/original-email-to-employees/. The Voluntary Early Retirement Authority allows employees at federal "agencies that are undergoing substantial restructuring" and who meet lower age and service requirements to retire. "Voluntary Early Retirement Authority," Office of Personnel Management, accessed October 7, 2025, https://www.opm.gov/voluntary-early-retirement-authority/.

## 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]

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 OIG found that survey scores for communication, transparency, and information sharing were stable and similar to VHA averages from FYs 2022 through 2024. OIG questionnaire respondents indicated that executive leaders changed their communication methods.[27]

In an interview, executive leaders described multiple communication methods, including

- a weekly bulletin,
- regular visits to staff at their work locations,
- town halls,
- twice monthly Director's open forums, and
- daily tiered huddles (short meetings between leaders and staff to share problems and identify solutions).

The Director discussed almost daily interactions with staff and veterans at the facility entrance, and executive leaders' participation in monthly employee engagement events such as ice cream socials, as an example of actions taken to increase visibility and interaction with staff. Additionally, executive leaders rotate on-call duties to ensure staff working evenings, holidays, and weekends have direct access to an executive leader in case of emergencies.

[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] The OIG administered the facility-wide questionnaire between February 18 through March 5, 2025, and received 388 responses. As of March 18, 2025, the facility had 3,353 staff.

## 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.

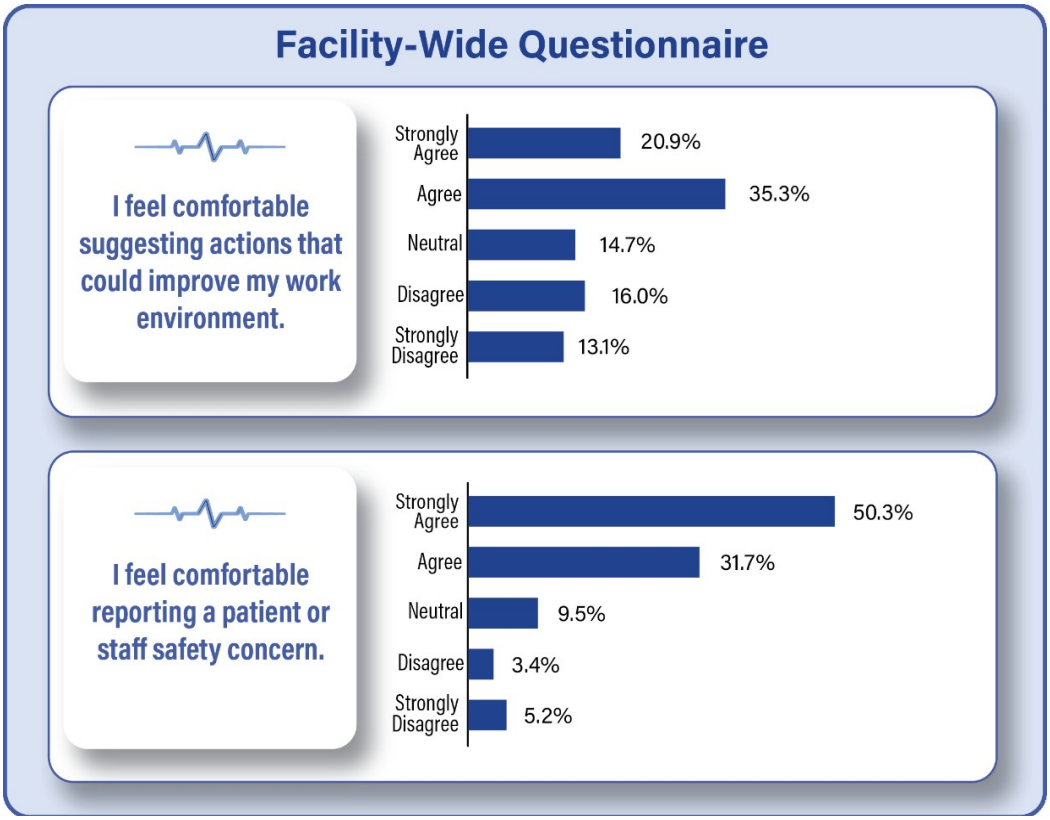


***Figure 5.*** *Employees' perceptions of facility culture.*
*Source: OIG questionnaire responses.*

The OIG also reviewed All Employee Survey data on employee satisfaction and found the facility's best places to work score dropped from FY 2023 to FY 2024.[30]

[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.

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

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. Psychological safety scores were below the VHA average between FYs 2022 and 2024 and did not change significantly over that time. However, the Chief of Staff said employees' willingness to ask questions during town halls and report patient safety events demonstrated improved psychological safety.

Executive leaders told the OIG that employees felt empowered to suggest ways to improve the facility's culture. The Director said patient safety and HRO principles were the cornerstones of the culture, and employees' open communication with leaders led to them address and resolve issues to prevent patient harm.

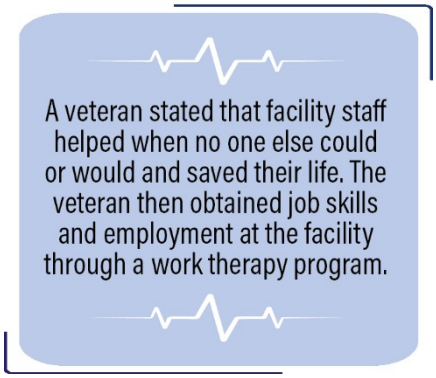


***Figure 6.*** *Highlighted information related to the staff survey. Source: OIG facility-wide questionnaire response.*

## Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[31] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

Executive leaders told the OIG they used a survey to monitor veterans' trust and experiences of care and discovered a decrease in satisfaction among those who had been discharged from the hospital. In response, the Director and ADPCS said they personally called recently discharged veterans to inquire about their experiences. The Director gave an example of a recently discharged veteran who during a call, stated to the Director that they were unsure if they should take a nutritional supplement after surgery. The Director then asked a pharmacist to call the veteran to clarify instructions.

In an OIG questionnaire, patient advocates were divided in their views of executive leaders' responsiveness to veterans' concerns. In the questionnaire, patient advocates shared some of the veterans' top concerns as appointment delays and staff not returning telephone calls. Executive leaders said they implemented a new appointment scheduling system in 2024 that required staff to manually transfer approximately 50,000 to 60,000 previously scheduled appointments into the new system. The leaders told the OIG that staff inadvertently did not schedule some appointments during the transition; however, they received help from VISN staff to schedule the appointments, and the incidents did not lead to patient harm.

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

The leaders also acknowledged challenges in the past with veterans' calls going to inactive voicemails, instead of the VISN call center. To address this, the Chief of Staff reported that staff routinely tested phone extensions to ensure they were still operational and updated them when needed.

# 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.[32] 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 whether there were repeat findings and identify areas in continuing need of improvement.

***Figure 7.*** *Richard L. Roudebush Veterans' Administration Medical Center part of the VA Indiana Healthcare System.*
*Source: "VA Indiana Health Care," Department of Veterans Affairs, accessed August 28, 2025, https://www.va.gov/indiana-health-care/locations.*

## Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] 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.[34]

[32] VHA Directive 1608(1).

[33] 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.

[34] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; 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.

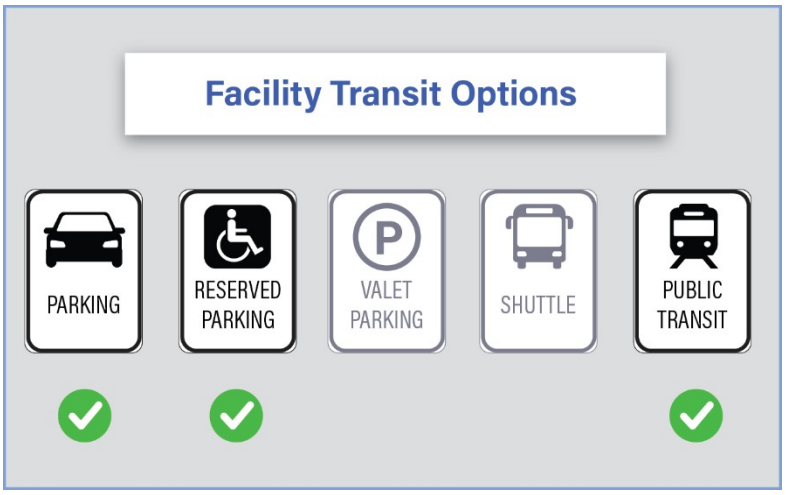


***Figure 8.*** *Transit options for arriving at the facility.*
*Source: OIG observation and analysis of documents.*

The OIG team used the navigation link on the facility's website and found the instructions easy to follow. On arrival, the OIG noted signs that directed veterans to available parking. The OIG observed ample parking spaces with sufficient lighting, a designated parking area for those with disabilities, and emergency call boxes. The OIG further noted a public bus stop located a short walk from the main entrance.

## Main Entrance

The OIG inspected the main entrance to determine whether 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.[35] The main entrance had a passenger loading zone and canopy, power-assisted doors, and available wheelchairs. Although the OIG observed a small, enclosed construction area inside the main entrance, walkways remained open and easy to navigate.

The entrance opened into a two-story atrium with large panoramic windows that provided natural light, along with additional lighting mounted on the walls. Also near the main entrance, the OIG noted an information desk staffed by one employee, and a café with seating to relax and socialize.

[35] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

## 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.[36]

The OIG observed signs that clearly guided veterans throughout the building. The signs and directional markers were large and easy to read. There were also color-coded maps on walls listing various services.


***Figure 9.*** *Accessibility tools available to veterans with sensory impairments.*
*Source: OIG observation and analysis of documents.*

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] The OIG observed braille signs in elevators, and a mobile phone application that provided turn-by-turn directions to the destination. An information desk employee said transportation staff helped veterans with sensory impairments reach their destinations, as needed.

## 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.[38] The OIG learned through a questionnaire that six nurses and one nurse practitioner had additional responsibilities as toxic exposure screening navigators. The OIG confirmed there were no overdue screenings at the time of the inspection in March 2025.

[36] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

[37] 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.

[38] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

The OIG observed toxic exposure screening handouts at the main entrance information desk and in a primary care clinic. The Chief Nurse for Primary Care reported that staff screen most veterans during primary care appointments, and registered nurses proactively reached out to veterans that had not been seen by primary care in recent years to complete the screening. Additionally, a respondent to the OIG questionnaire indicated screenings also occurred at monthly veteran town halls.

## 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.[39]

The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG observed several pallets of supplies and patient beds stored in the basement hallway under signs prohibiting storage. The OIG reviewed a Joint Commission report that found an exit blocked by several racks of equipment stored in the hallway.[40] In addition, a VISN annual facility evaluation revealed obstructed exit pathways in several areas at the facility.[41]

The Joint Commission requires exit paths to be clear of obstructions to ensure patients and staff can safely move between areas and leave buildings.[42] When asked, the acting Chief Supply Chain Officer explained the supply receiving room lacked sufficient space to store shipments. The chief added that until there was enough space, staff placed the supplies in the hallway each morning and removed them by noon after distributing them throughout the facility.

The Chief of Healthcare Technology Management reported that beds were awaiting repair or redistribution after cleaning. The engineering and healthcare technology departments planned to modify the bed storage area or find a new location. Although the items maintained the Joint Commission's required hallway clearance and did not obstruct an exit, executive leaders should

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

[40] The Joint Commission is an organization that evaluates medical facilities to improve quality of care and decrease patient harm. "About Us," The Joint Commission, accessed February 14, 2025, https://www.jointcommission.org. A Joint Commission unannounced inspection of the Indiana VA Healthcare System took place March 19–22, 2024. The Joint Commission, *Final Accreditation Report VA Medical Center—Richard L. Roudebush VAMC*, March 23, 2024.

[41] The VISN annual evaluation of the VA Indiana Healthcare System took place July 15–19, 2024.

[42] The Joint Commission, E-dition *Standards Manual*, LS.02.01.20, August 1, 2024.

store equipment and supplies consistent with their facility's signs of not storing items in the basement hallway.

In a comprehensive healthcare inspection report from 2024, the OIG issued a recommendation for the Associate Director to maintain a safe and clean environment.[43] During this inspection, the OIG examined four clinical areas — the Emergency Department, the Blue Clinic (a primary care clinic), the Critical Care Unit, and the Medical-Surgical Unit on the seventh floor — and observed cleanliness issues in the following locations:

- Main entrance
  - Debris on the floor in multiple areas
- Emergency Department
  - A new patient walker and cleaning supplies stored in the soiled utility room
  - Corrugated boxes stored in the clean storage room[44]
- Medical-Surgical Unit, seventh floor
  - Holes, chipped paint, and residue on the walls in a patient room
  - Unused supplies and debris on a clean supply room floor
  - Dust on several air ventilation grills and the top of the automated medication dispensing cabinet[45]

VHA requires facilities to have a safe and clean environment.[46] When the OIG asked about a work order for the damaged patient room, the Nurse Manager and Assistant Nurse Manager said they were unaware of it and therefore had not entered a work order to repair the issues. While OIG recognized the facility's efforts to address these issues, due to the number of concerns, the OIG recommended the Assistant Director ensures staff maintain a consistently clean environment throughout the facility to prevent repeat environment of care findings. To address it,

[43] VA OIG, *Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*, Report No. 22-03165-46, January 3, 2024.

[44] Corrugated boxes are an infection control concern because they "are susceptible to moisture, water, vermin and bacteria during warehouse or storeroom storage, as well as transportation environments. Boxes and containers may have been exposed to unknown and potentially high microbial contamination." "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed August 4, 2025, https://www.jointcommission.org/knowledge-library/support-center/standards-faqs.

[45] "First introduced in hospitals in the 1980s, an automated dispensing cabinet (ADC), is an electronic, point-of-care storage device that serves as a method for medication distribution." "Guidelines for the Use of Automated Dispensing Cabinets," Institute for Safe Medication Practices, accessed April 10, 2025, https://www.ismp.org/ADC.

[46] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023. Corrugated boxes cannot be stored in a clean or sterile area, except for "storage of prosthetic devices and durable goods/DME [durable medical equipment] stored for outpatient care unless they are stored with sterile supplies." VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

the Director stated Quality Management Service staff trained clinical leaders and staff on topics such as infection prevention and reusable equipment cleaning and storage, and leaders gave Environment Management Service staff access to locked areas to complete daily cleaning. Staff will inspect inpatient rooms for issues like damaged walls, report them for timely repair, and complete monthly environment of care reviews until they achieve sustained compliance (see OIG Recommendations and VA Responses).

## General Inspection

Maintaining a safe healthcare environment is an integral part to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG observed a tripping hazard near the Emergency Department's entrance that was caused by a raised flexible joint between two concrete sections. Although staff placed four large traffic cones in the area as a warning, the cones were easily moved and did not eliminate the risk. Engineering Department staff immediately installed permanent guard rails directly over the joint to eliminate the hazard. When asked about long-term repairs, the Chief of Engineering said the repair was part of a larger project that was awarded to a contractor, who indicated the repairs would be extensive.

The OIG also observed some noncritical reusable medical equipment uncovered in clean storage areas of the Medical-Surgical Unit on the seventh floor and Emergency Department. In the Blue Clinic, which did not have a designated clean storage area because of a lack of space, the OIG found covered and uncovered equipment in the hallway.

When the OIG asked about the process of storing the equipment, the Infection Prevention Coordinator said all clean equipment should be covered in plastic bags, which indicates the equipment is clean and ready for use. The Assistant Chief of Environment Management Services and nurse managers of the Medical-Surgical Unit, Emergency Department, and primary care areas had varied responses about who is responsible for covering the equipment with the bags after cleaning. One manager indicated Environment Management Service staff were responsible, while the assistant chief said it was nursing staff's responsibility.

VHA requires that staff store clean and soiled items separately to prevent and control the transmission of infections.[47] When staff do not know whether the equipment is clean or dirty, there is an increased risk of infection if used. The variation in clean, noncritical reusable equipment storage practices suggested staff did not consistently identify cleaned and ready-to-use equipment. The OIG recognized staff's efforts to address these issues by cleaning the

[47] VHA Directive 1131.

reusable non-critical medical equipment and wrapping them with plastic bags according to the facility's policy and therefore did not make a recommendation.[48]


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.[49] 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.[50]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. After reviewing documents and interviewing staff, the OIG determined that facility staff had an updated policy, established processes, and service-level workflows (which describe team member roles in the communication process) for the communication of test results that complied with the latest VHA directive, including communication time frames.[51]

View alerts are notifications in the electronic health record system that signal staff to information such as test results. The Chief of Pathology and Laboratory Medicine said providers who order tests receive a view alert once laboratory staff enter the results in a patient's electronic health record, and as a courtesy, diagnostic providers also call the provider with abnormal results.[52] The Diagnostic Radiology Section Chief said staff audit view alerts for each provider and escalate

[48] Roudebush VA Medical Center, *Cleaning and Disinfection of Non-Critical Reusable Medical Equipment*, MCP [medical center policy] SPS-06, April 8, 2022.

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

[50] 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.

[51] Roudebush VA Medical Center, *Communicating Test Results to Patients*, MCP 11-49, October 23, 2024; VHA Directive 1088(1).

[52] VHA defines a view alert as a computerized patient record system (CPRS) [or electronic]-based notification designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, *A Checklist to Improve CPRS 'View Alert' Notifications*, August 15, 2016.

delays in taking action on the results to service chiefs and the Chief of Staff. Moreover, the Chief of Staff told the OIG the Quality Safety and Value Committee tracked unaddressed view alerts, and committee members took corrective action when they identified issues.

## Action Plan Implementation and Sustainability


***Figure 10.*** *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[53] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether action plans were implemented, effective, and sustained.

The OIG reviewed a previously published OIG healthcare inspection report and found no open recommendations.[54] Quality management staff explained that various committee members monitor action plans and report overdue actions to executive leaders. Quality management staff also meet regularly with the Director to review open actions and address barriers to resolving them timely.

## 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.[55] 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.[56] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality Management staff, including the Patient Safety Manager and a Systems Redesign Coordinator, said they review patient safety event reports. The Patient Safety Manager reviews the reports daily and shares them with executive leaders. The Systems Redesign Coordinators

[53] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.
[54] VA OIG, *Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center in Indianapolis, Indiana*.
[55] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[56] VHA Directive 1050.01(1).

initiate improvement projects based on patient safety event trends and any issues identified through various committee meetings. Executive leaders expressed they frequently communicate with staff at service-level meetings and during their visits to work areas, so staff could discuss opportunities for improvement.

The Patient Safety Manager reported sharing feedback from improvement initiatives in various ways, including distributing clinical fact sheets about a new process or any change in processes already in place. Staff also received Great Catch awards for reporting safety events that could have caused patient harm, and Great Investigators awards for identifying why safety events happened to prevent them from happening again.

The ADPCS provided an example of an employee-led initiative that decreased hospital-acquired pneumonia rates by tracking nurses' completion of infection prevention assessments. Employees presented the initiative results at two national conferences.


The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[57] 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.[58] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[59] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Through interviews with primary care leaders, the OIG learned there were eight provider, two nurse, and nine medical support assistant vacancies. The leaders offered positions to providers, but citing government employment uncertainty, some turned down the offers. The Chief of

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

[58] 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).

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

Primary Care said leaders considered recruiting nurse practitioners to fill vacant provider positions and were having providers from the VISN's Clinical Resource Hub cover until then.[60]

The Chief Nurse of Primary Care told the OIG they have applicants for nursing positions, but positions at rural locations usually took longer to fill. The Chief of Health Administration Services discussed challenges in recruiting medical support assistants because the positions were paid low salaries, and candidates frequently declined job offers when they found higher paying positions in the community. A staff member told the OIG that due to vacant positions, there was only one medical support assistant for two teams at times, despite VHA's guidelines requiring a one-to-one ratio. The Chief of Health Administration Services was actively recruiting to fill the vacant positions.

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.[61] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[62]

The Patient Centered Management Module Coordinator reported meeting with primary care leaders daily to discuss panel data and sizes.[63] The OIG reviewed data that showed primary care team panels averaged 98 percent of VHA's maximum recommended size of 1,200.[64] The coordinator said that due to staffing vacancies, several panels exceeded the maximum number of patients recommended per team.[65]

Primary care staff voiced concerns with the number of patients on each panel and said it was difficult to schedule patients with their assigned team. The OIG found that appointment wait times for new patients had increased from 20 to 25 days over the past three years, exceeding the VHA standard of 20 days. The Director attributed the increase in wait times to patients who choose to schedule further out due to travel plans or other personal reasons.

[60] Clinical Resource Hubs are "programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed February 10, 2025, https://www.patientcare.va.gov/CRH.asp.

[61] "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).

[62] VHA Directive 1406(2).

[63] The patient centered management module coordinator is responsible for calculating, adjusting, and monitoring panel sizes. VHA Directive 1406(2).

[64] VHA Directive 1406(2).

[65] When a panel size is over 100 percent, primary care leaders have exceeded the maximum recommended number of patients assigned to a primary care team. VHA Directive 1406(2).

## Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[66] 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.

During interviews, primary care leaders and staff discussed their concerns about how a new scheduling process affected patient care. Leaders said staff previously scheduled patients' laboratory appointments before their primary care appointments, which allowed providers to review test results during the visit. The OIG discussed the issue with leaders who said they changed the process due to a new scheduling system, which required staff to schedule 11,000 pending laboratory appointments. The Chief of Staff said the amount of work was overwhelming and decided to stop scheduling laboratory appointments. Instead, they requested patients arrive prior to the primary care appointment and go to the laboratory to be seen. Leaders and staff described how the process change led to patients arriving late to appointments or arriving without completing the requested laboratory tests.

The Chief of Primary Care and staff described instances when patients forgot to complete their laboratory work, and without the results, the team could not provide efficient and timely care during the primary care appointment. However, the OIG reviewed patient safety event reports and did not find any events related to this situation, and in an interview, quality management leaders denied being aware of any patients harmed. According to one primary care staff member, the process to schedule laboratory appointments prior to being seen in primary care remained the same at community-based clinics.

The Chief of Health Administration Service emphasized there was no VHA requirement to schedule laboratory appointments. The Chief of Staff further explained that staff should call patients before their primary care appointments to remind them to complete their laboratory tests; however, the Chief Nurse of Primary Care said staff were not always able to call patients due to competing priorities. Therefore, leaders contacted VHA's national office of primary care for recommendations regarding clinic efficiency and laboratory appointments, and received information to contact other facilities that had similar processes in place.

The OIG recommended executive leaders review the change in laboratory scheduling practices and minimize its effect on clinic efficiency. In response, the Director explained that leaders and Primary Care Service staff updated patient instructions on appointment reminder postcards, letters, and text messages to ensure patients complete needed tests before primary care visits. Quality, Safety, and Value staff will monitor these process changes for any patient safety

[66] VHA Handbook 1101.10(2).

concerns and until they achieve sustained compliance (see OIG Recommendations and VA Responses).

## 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 facility's veteran enrollment increased since the act's implementation in August 2022. However, leaders stated it had not affected efficiency.


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

## Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[67]

The Homeless Outreach and Community Partnerships Program Coordinator shared the success of a 90-year-old veteran who had been living in poor conditions, then was referred to the program. Through outreach and coordination, program staff were able to place the veteran in permanent housing.

***Figure 11.*** *Program success story. Source: OIG questionnaire responses.*

### 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).[68] VA uses the Department of Housing and Urban Development's point-in-

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

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

time count as part of the performance measure that "estimates the homeless population nationwide."[69]

The VHA Homeless Programs Office exempted the facility from the HCHV5 performance measure in FYs 2022 and 2023 because there was a low population of unsheltered veterans in the area.[70] In FY 2024, the program office reinstated the performance measure at the facility, and the program exceeded the target.[71] The Homeless Outreach and Community Partnerships Program Coordinator attributed this success to homeless program staff's outreach, additional outreach staff to maximize their presence in the community, and staff's timely response to referrals.

Additionally, program staff who participated in the annual point-in-time count found it to be accurate and useful in identifying unsheltered veterans. Program staff worked closely with the facility's health benefits staff to identify veterans' eligibility for VA health care and enrollment into the program. The Chief of Social Work Service informed the OIG that homeless program staff also educated facility staff about homeless services.

[69] 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.

[70] The VHA Homeless Programs Office established guidelines to exempt facilities when they would not meet local targets due to low populations of unsheltered veterans. VHA Homeless Programs, *HCHV5: Engagement of Unsheltered Veterans—FY23 Exempted Sites*.

[71] VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

## 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).[72]

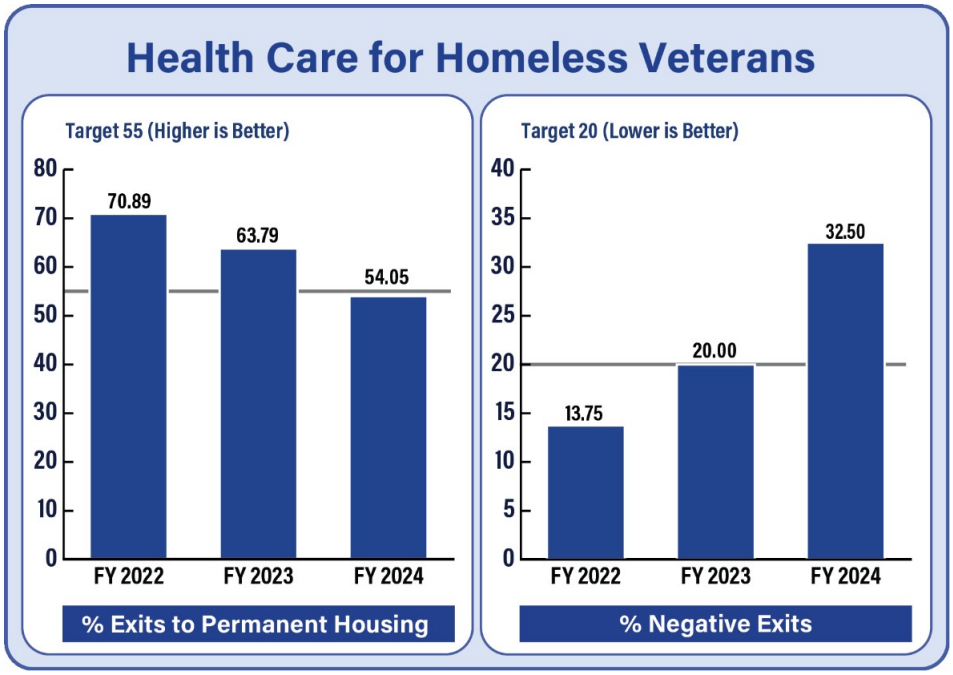


***Figure 12.*** *HCHV program performance measures.*
*Source: VHA Homeless Performance Measures data.*

The facility exceeded the HCHV1 target in FYs 2022 and 2023, but it fell short of the target by less than 1 percent in FY 2024. The Homeless Outreach and Community Partnerships Program Coordinator attributed this success to VA staff meeting weekly with contract program staff to discuss ways to address issues, such as veterans with legal issues who have difficulty finding housing or employment.[73]

The facility met the HCHV2 target in FYs 2022 and 2023 but had a 12.5 percent increase in negative discharges in FY 2024. The coordinator stated that some veterans may not have

[72] 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*.

[73] In addition to outreach services, HCHV programs include transitional housing and case management services through contracts with community providers. "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

understood all the residential group's rules, leading to negative discharges. The coordinator added that staff are resolving discharge issues early in the admission process by explaining the residential group's rules, providing behavioral interventions, and helping veterans find different housing when the rules and group living are not compatible.

## 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."[74] 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.[75]

### 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).[76] The facility did not meet the target from FYs 2022 through 2024. Program staff reported that veterans used fewer vouchers, and staff encountered delays working with a local housing authority.

Staff discussed collaborating with community partners to identify homeless veterans who reside in rural areas, as well as continued teamwork with the HCHV program. In addition, the Homeless Outreach and Community Partnerships Coordinator stated program staff found permanent housing for veterans who were displaced due to a fire in a transitional housing program last fall.

A program supervisor said program staff reviewed referrals weekly from both VA and community providers, then contacted the veterans to complete an initial assessment. Staff also described challenges in communicating with veterans who did not have phones and struggled with technology. To address this barrier, staff contacted community partners to locate veterans in community shelters and assist them with applying for services online.

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

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

[76] 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*.

### 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).[77] The facility did not meet the target in FY 2022 but exceeded it in FYs 2023 and 2024. The coordinator said leaders hired an experienced candidate in vocational rehabilitation, which helped the program exceed the target in the last two years.

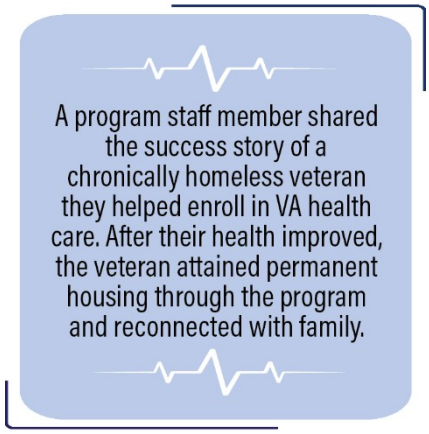


***Figure 13.*** *Program success story. Source: OIG questionnaire response.*

Program staff informed the OIG that they help veterans with transportation, employment, filling out housing applications and paying security fees; getting treatment for medical, mental health, and substance use disorders; and managing other financial issues.

## Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[78] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and re-entry into society after incarceration. By improving access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[79]

### Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[80] The facility exceeded the target in FYs 2023 and 2024. The Homeless Outreach and Community Partnerships Coordinator/Program Manager informed the OIG that staff educated community providers and attended outreach events to promote the program. Additionally, the manager highlighted the monthly legal clinic held at the facility, and

[77] 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*.

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

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

[80] 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*.

staff's presence at veterans treatment courts, jails, and prisons as contributing factors to success in identifying veterans and enrolling them in the program.[81]

## Meeting Veteran Needs

Program staff told the OIG that they assessed veterans enrolled in the program. Some of the veterans needed assistance with substance abuse and mental health treatment, housing, and primary care access. The specialist added that most veterans called about civil legal issues, such as driver's license suspensions. To address these needs, staff referred veterans to facility and community programs.

However, the Homeless Outreach and Community Partnerships Coordinator informed the OIG that enrolled veterans who had legal issues experienced stigma from healthcare providers. The coordinator added that some veterans with warrants were reluctant to seek care at the facility because they feared they would be arrested. In response, staff developed a local social work policy for facility staff on how to engage veterans with legal issues and follow the practices of the fugitive felon program.[82]

Staff shared that a local police officer contacted Veterans Justice Program staff regarding a veteran experiencing a mental health crisis. Program staff helped the veteran get admitted to the VHA inpatient psychiatric unit. The veteran was enrolled in the program, graduated from veterans treatment court, and became a certified recovery specialist and mentor coordinator with the Indianapolis veterans treatment court.

***Figure 14.*** *Program recognition. Source: OIG interview and analysis of document.*

The Veterans Justice Outreach Specialist/Healthcare for Re-Entry Specialist told the OIG that program staff were developing a virtual legal clinic for incarcerated veterans, and advocating for a veterans dorm in minimum, medium, and maximum security level prisons. The OIG learned during the interview that staff worked with nine veterans treatment courts and staff stated the veterans treatment courts were more effective than public courts at reducing repeat incarceration rates. Staff reported that some veterans who graduated from the program served as mentors for new veterans entering treatment court.

[81] "Many legal service providers offer free legal clinics in VA facilities." "Office of General Counsel, Legal Help for Veterans," Department of Veterans Affairs, accessed April 7, 2025, https://www.va.gov/OGC/LegalServices.asp. Veterans treatment courts are "community initiatives that work to help Veterans get treatment for their unique clinical needs, within the context of the criminal justice system." "Justice Involved Veterans and Treatment Court," Office of Health Equity, Veterans Health Administration, Department of Veterans Affairs, accessed August 1, 2023, https://www.va.gov/HEALTHEQUITY/docs/Justice_Involved_Veterans_Info_Brief_Final.pdf.

[82] The Fugitive Felon Directive "states policy and standards for ensuring compliance with the prohibition against providing certain benefits, including health care, to Veterans and Veterans' dependents who are determined to be fugitive felons." VHA Directive 1520, *Fugitive Felon Program*, December 5, 2024.

# Conclusion

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

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to facility cleanliness, and laboratory appointments. 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.

# OIG Recommendations and VA Responses

## Recommendation 1

The Assistant Director ensures staff maintain a consistently clean environment throughout the facility to prevent repeat environment of care findings.

_X_ Concur

____ Nonconcur

Target date for completion: July 2026

### Director Comments

The Assistant Director implemented corrective actions to ensure that staff maintain a consistently clean environment throughout the facility to prevent repeat environment of care findings. At the time of discovery, clean supplies were removed from soiled utility rooms, unused supplies were discarded, and corrugated boxes were cleared from clean supply areas. Just-in-time training was delivered by the Quality Management team to clinical leadership via the Nursing Quality Council meetings and to clinical staff which included education on infection prevention, medication safety, proper cleaning and storage of reusable medical equipment, preventative maintenance, linen, and fire safety.

Previously, Environment Management Service (EMS) staff did not have access to locked storage areas, including medication, clean, and dirty supply rooms. The Chief of EMS confirmed that on May 19, 2025, access was granted to all EMS staff, enhancing their ability to perform daily cleaning tasks and maintain ventilation systems within these areas. At that time, EMS supervisors implemented a verification process for all locked areas, incorporating data tracking capabilities. This information is collected and reviewed by EMS Supervisors for internal auditing purposes.

On May 9, 2025, after review of current Environment of Care (EOC) tracers, ventilation system assessments were integrated into EOC tracers. Alongside EOC tracers, on November 26, 2025, EMS leaders initiated education to supervisors inspecting inpatient rooms during patient discharge cleaning to identify and report issues such as chipped paint or holes in walls. Reports are directed to the unit's medical support assistants, who will then initiate the appropriate work orders in Maximo.

Patient care areas will continue to complete at least one EOC tracer per department each month. Tracer data collection will include cleanliness of areas, vents, proper storage of items in the clean and dirty supply rooms, corrugated cardboard box removal, and the integrity of walls in patient care areas, including patient rooms. Data will be compiled and presented to the Comprehensive

Environment of Care Committee monthly until a sustained 90 percent compliance rate over six months is achieved.

## Recommendation 2

Executive leaders review the change in laboratory scheduling practices and minimize its effect on clinic efficiency.

_X_ Concur

____ Nonconcur

Target date for completion: July 2026

### Director Comments

The scheduling process for laboratory appointments was reviewed by executive leadership and the Primary Care team. On June 10, 2025, changes were initiated to modify the patient appointment reminder postcards and letters to include "Please arrive at least one hour early for any lab work, if ordered, and at least 30 minutes before your appointment to check in". These updates were completed and revalidated August 28, 2025, for the postcards and September 3, 2025, for the letters.

In addition, VEText is an automated interactive text message system to remind Veterans of upcoming appointments which allows responses for confirmation and cancellation in response to that reminder. This program aims to inform Veterans with mobile phone numbers on file. With support from the clinical application coordinators, Primary Care introduced a reminder via VEText on November 24, 2025, instructing patients to "Please arrive at least one hour early for any scheduled tests, if ordered, and at least 30 minutes prior to your appointment to check in." This initiative ensures patients have adequate time to arrive at phlebotomy for necessary testing prior to their primary care visit, thereby improving clinic efficiency. The Quality, Safety, and Value team has and will continue to monitor Joint Patient Safety Reports for any patient safety concerns.

# 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. 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 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.[2] 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 take full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The OHI 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.*[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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from March 17 through 21, 2025. During site visits, the

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

[3] 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.

[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.

OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

Without current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[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.*

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

# Appendix C: VISN Director Comments

## Department of Veterans Affairs Memorandum

Date: December 11, 2025

From: Interim Director, Veterans Affairs (VA) Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: Healthcare Facility Inspection of the VA Indiana Healthcare System in Indianapolis (2025-00207-HI-1493)

To: Director, Office of Healthcare Inspections (54HF04)
Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the report findings and recommendations of the Healthcare Facility Inspection of the VA Indiana Healthcare System.
2. I have reviewed the documentation and concur with the medical center's response as submitted.
3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

*(Original signed by:)*

Jill Dietrich Mellon, JD, MBA, FACHE

# Appendix D: Facility Director Comments

## Department of Veterans Affairs Memorandum

Date: December 11, 2025

From: Director, Richard L. Roudebush VA Medical Center (583/00)

Subj: Healthcare Facility Inspection of the VA Indiana Healthcare System in Indianapolis (2025-00207-HI-1493)

To: Interim Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

1. We appreciate the opportunity to review and comment on the Healthcare Facility Inspection of the VA Indiana Healthcare System in Indianapolis. We are requesting that the contact for the environment of care finding referencing the Associate Director be changed to the Assistant Director.
2. I concur with the recommendations and will take corrective action.
3. Should you need further information, please contact the Deputy Chief of Quality, Safety, and Value.

*(Original signed by:)*

Michael E. Hershman, MHA, FACHE
Director, VA Indiana Healthcare System

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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Director, VA Indiana Healthcare System (583)

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