US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Beckley Healthcare System in West Virginia

Healthcare Facility Inspection	**25-00245-60**	**February 24, 2026**

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 inspected the VA Beckley Healthcare System (facility) from July 7 through 10, 2025, and examined the quality of care provided using five content domains.[1]

What the OIG Found

- **Culture.** The OIG examined system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** The OIG inspected the main entrance and patient care areas and compared findings from prior inspections to determine if there were recurring issues. The OIG made no recommendations.
- **Patient Safety.** The OIG assessed the facility's processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** The OIG evaluated primary care and community care team staffing and access to care.[2] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The OIG assessed programs that offer medical care and social support services to vulnerable veterans who are homeless and recently incarcerated. The OIG made no recommendations.

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.

What the OIG Recommended

The OIG did not make any recommendations.

[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] "VA provides care to veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 7, 2025, https://www.va.gov/communitycare.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes C and D). No further action is required.

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

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

FACILITY IN CONTEXT

VA Beckley Healthcare System
Beckley, West Virginia
Level 2-Medium Complexity
Raleigh County
Hospital Referral Region: Charleston

Description of Community

POPULATION

Female **683,711**	Male **665,519**
Veteran Female **8,172**	Veteran Male **87,921**

Homeless - State **1,375**
Homeless Veteran - State **122**

MEDIAN INCOME

$44,234

EDUCATION

85% Completed High School
48% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **262**

SUBSTANCE USE

25.3% Driving Deaths Involving Alcohol
14.8% Excessive Drinking
982 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	435,271
Carpool	43,697
Work at Home	22,630
Walk to Work	17,147
Other Means	6,425
Public Transportation	4,011

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**33.5 Minutes, 26 Miles**
Specialty Care	**66 Minutes, 56 Miles**
Tertiary Care	**181 Minutes, 177.5 Miles**

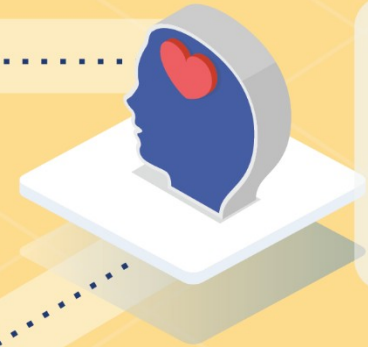
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **3,702**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	32%
<65 without Health Insurance	13%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

3,601

2 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

3.79 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
25	42

Health of the Facility

UNIQUE PATIENTS

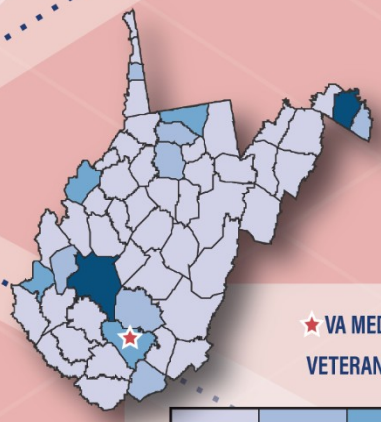
Unique Patients VA and Non-VA Care	13K
Unique Patients VA Care	12K
Unique Patients Non-VA Care	9K

COMMUNITY CARE COSTS

Unique Patient $27,211	Outpatient Visit $239
Line Item $1,466	Bed Day of Care $331

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.77%
Facility Total Loss Rate	11.73%
Facility Retire Rate	2.67%
Facility Quit Rate	8.59%
Facility Termination Rate	0.46%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.37% 2.12% 3.86% 5.59% 7.33% 9.06%

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 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Each review includes a set of content domains: culture, environment of care, patient safety, integrated veteran care, and veteran-centered safety net.

Healthcare Facility Inspection reports provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care delivered; and highlight specific actions leaders and staff can take to improve patient safety and care.

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

In 2018, VHA officially began the journey to become a high reliability organization (HRO) and set goals to improve accountability and reliability and reduce patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

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[1] "About VHA," Department of Veterans Affairs, accessed August 8, 2025, https://www.va.gov/health/aboutvha.

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

[3] "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.)

Content Domains

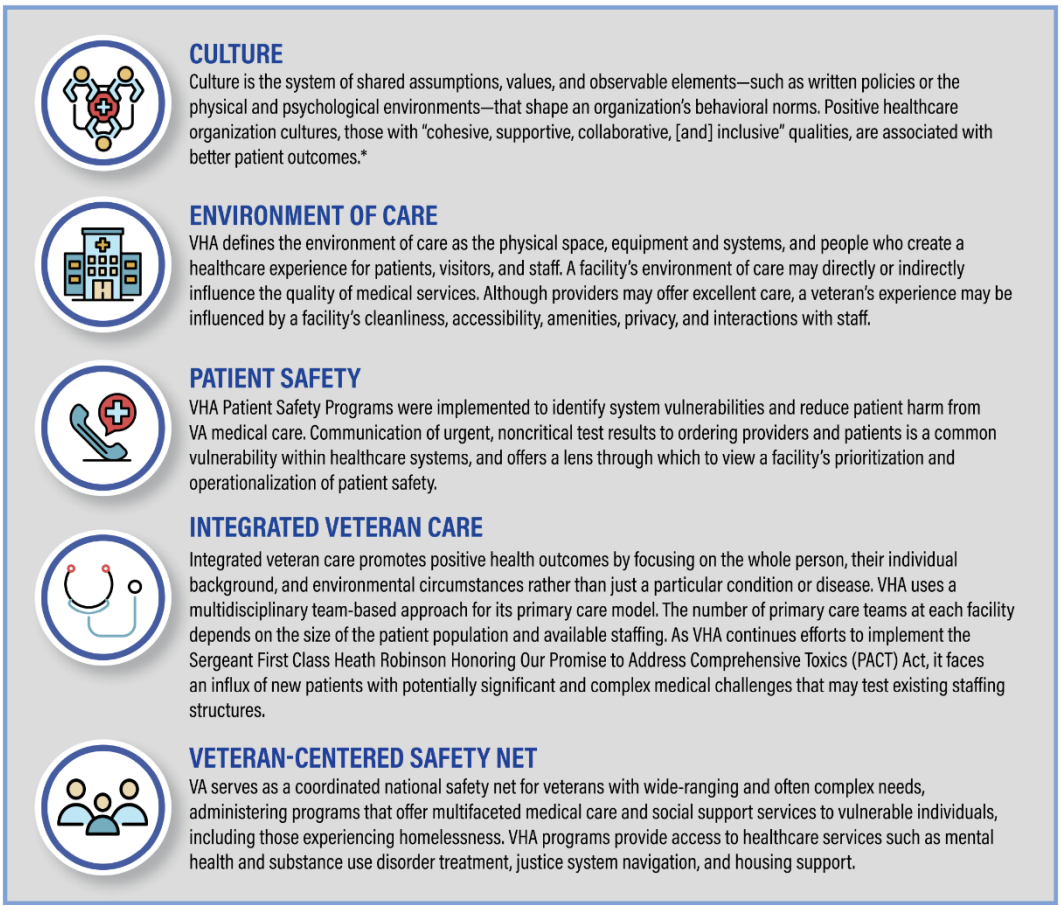

Figure 2. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review, (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; VHA Directive 1088(1), Communicating Test Results to Providers and Patients, July 11, 2023, amended September 20, 2024.

The VA Beckley Healthcare System (facility) includes a medical center in Beckley and two community-based outpatient clinics—Princeton VA Clinic and Greenbrier VA Clinic. In fiscal year (FY) 2024, the medical care budget was $283,550,804. It had 70 operating beds (20 hospital and 50 community living center beds) and served approximately 14,000 enrolled veterans.[4]

Figure 3. *Facility's main entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the facility from July 7 through 10, 2025. The executive leaders consisted of the acting Executive Director (Director), acting Associate Director, Chief of Staff, and acting Associate Director for Patient Care Services. The leaders had been working together since March 2025.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[5] The OIG administered a facility-wide questionnaire, reviewed VA's All Employee Survey and Veterans Signals (VSignals) survey scores (which provide information about veterans' experiences after an appointment and their level of trust in VA), interviewed leaders and employees, and reviewed data from patient advocates and veterans' feedback.[6]

System Shocks

During an interview, executive leaders reported leadership changes and hiring challenges as system shocks. Executive leaders said the Associate Director for Patient Care Services transferred to another facility in 2022, the former Director and Chief of Staff retired in 2023,

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

[5] 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.

[6] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," Department of Veterans Affairs, accessed August 4, 2025, https://www.va.gov/HEALTH/patientadvocate/. 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.

then the Associate Director transferred in 2024.[7] Following the former Director's retirement, three acting Directors served in the position until the current Director was appointed in June 2024. However, in March 2025, the current Director was detailed to another facility.

Leaders described each acting Director as having their own views and priorities, which resulted in change and confusion. In response, leaders requested permission from the Veterans Integrated Service Network (VISN) to use current leaders to fill the positions.[8] For example, at the time of the site visit in July 2025, the Associate Director was serving as the acting Director, and the Chief Nurse of Acute Care was the acting Associate Director for Patient Care Services.

Leaders also identified the difficulty in hiring administrative staff because of the January 2025 federal hiring freeze as a system shock.[9] Leaders reported that although they can hire clinical staff, who are exempt from the hiring freeze, they are unable to recruit the administrative staff to support the clinical staff.

Additionally, leaders explained that because of the facility's rural location, compensation is lower compared to pay for the same positions in larger cities, especially for specialty care such as neurology and podiatry. Leaders said they rely on community care providers when the facility is unable to offer care.[10] Leaders struggle to hire nursing staff due to the lack of nursing education programs in the area. They have used recruitment incentives, such as additional training, with limited success.

Employee Experiences

Questionnaire respondents identified stress, burnout, and poor executive and service leaders as reasons employees are thinking about leaving the facility. Leaders reported they recognize leadership transitions have negatively affected employees and want to mitigate their concerns. Additionally, leaders said most questions they receive from employees are about the January 2025 return to in-person work requirement and possible reduction in force (layoffs).[11]

Leaders said the current Director emphasizes the importance of open and transparent communication. Leaders communicate and interact with employees through monthly town halls, weekly visits to different units and services, and meetings between the executive leaders and

[7] The current Chief of Staff and Associate Director initially served in acting positions until appointed in September 2024 and November 2024 respectively. The Associate Director for Patient Care Services was appointed to the position in August 2022.

[8] Veteran Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed December 3, 2025, https://www.va.gov/HEALTH/visns.asp.

[9] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

[10] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

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

service leaders. During meetings, executive leaders discuss events and information from the previous day with service leaders, who then share information with their employees. Additionally, leaders invite employees to join the meetings virtually and share information.

Veteran Experiences

According to VSignals data from the first and second quarters of FY 2025, 94 percent of respondents indicated they trust the facility.[12] Leaders said they are willing to meet with veterans to discuss concerns. The leaders also shared the patient advocate works with employees to resolve veterans' issues. The OIG reviewed information from the patient advocate that showed the most common complaints were employees' rudeness and lack of communication. To address these complaints, the patient advocate reported employees received customer service training to improve their interactions with veterans, and employees are updating the phone system to improve communication between veterans and their treatment teams.

Further, leaders said the Director attends resident council meetings in the community living center, as well as veterans' treatment groups in mental health, to obtain feedback on care at the facility. Although leaders reported they hold veteran town halls, the attendance is low. Leaders said they are trying to increase participation.

Attention to environmental design improves veterans' and staff's safety and experience.[13] The OIG assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The OIG also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

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.[14]

[12] VHA Directive 1003, *VHA Veteran Patient Experience*, April 14, 2020.

[13] "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

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

General Inspection

The OIG found the facility's exterior signs easy to follow. Parking spaces are directly in front of the main entrance, and a parking garage is nearby. The garage has emergency call boxes, cameras, and parking spaces accessible for those with disabilities, with some specifically designated for veterans with spinal cord injuries. In addition, contracted employees provide valet parking and shuttle services at the main entrance.

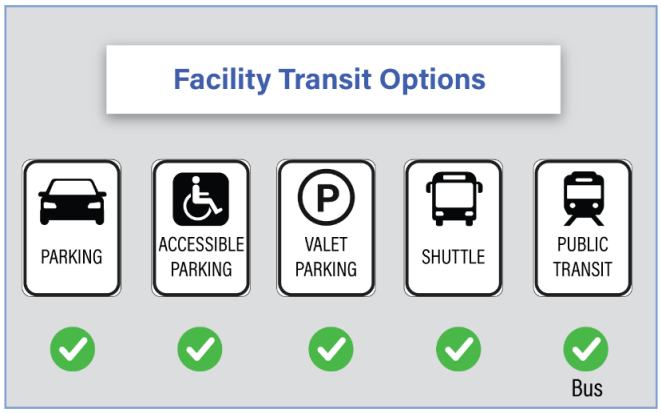

Figure 4. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The main entrance was well-lit and inviting. The OIG observed clear signs; a covered passenger loading zone; automatic, motion-sensing sliding doors; and clean, accessible wheelchairs inside the breezeway. The OIG noted color-coded directories on the walls to guide veterans to their destinations, such as red for the emergency room and tan for the pharmacy. Crosswalks outside the main entrance had detectable warning surfaces.[15]

Figure 5. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

Volunteers at the help desk said they are available to escort veterans to appointments as needed. The OIG noted the audiology clinic was directly across from the help desk, and volunteers explained that clinic staff assisted hearing-impaired individuals if requested. Additionally, OIG questionnaire respondents indicated staff supported sensory-impaired veterans through whiteboards for written communication, closed captioned televisions, and large-font educational materials.

In patient care areas and the community living center, the OIG found medical equipment had current inspection stickers, and staff properly stored contaminated medical waste in areas with restricted access. The OIG also observed that medication and supply rooms were secure and contained no expired medications or supplies.

[15] Detectable warning surfaces are "a standardized surface feature built in or applied to *pedestrian circulation paths* and other *pedestrian facilities* to warn of hazards." "Public Right-of-Way Accessibility Guidelines," Access Board, accessed December 4, 2025, https://www.access-board.gov/pedestrian-access-routes.

In FY 2024 and the first and second quarters of FY 2025, the facility met VHA's performance targets for staff to close identified environment of care deficiencies or create an action plan within 14 business days, and for an executive leader and core members of the Comprehensive Environment of Care Committee to attend environment of care inspections.[16] However, the facility did not meet VHA's target to document a performance improvement plan, including outcome measures, based on an identified environment of care trend in FY 2024.[17] A committee member stated staff did not document a performance improvement plan for FY 2024 because they were unable to use the VHA-required monitoring tool (Performance Logic) due to technical difficulties, which they have since resolved.

For FY 2025, staff developed a performance plan to reduce the use of unapproved personal electrical equipment, such as space heaters. The plan stated staff would change the medical center policy to include all prohibited electrical devices, update the deficiency inventory showing what areas did not meet requirements, and review areas for prohibited devices during environment of care inspections.

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

Communication of Urgent, Noncritical Test Results

The facility has policies and processes to communicate abnormal test results to providers, identify a surrogate when a provider is unavailable or has left the facility, and alert the provider about test results from community (non-VA) providers. Leaders and quality management staff said the electronic health record system automatically assigns a surrogate to receive test results if a provider is absent, which serves as a safety net if a provider does not assign one. Additionally, a supervising provider also receives results for all diagnostic tests ordered by physicians in training in case they leave the facility before the results are available.

[16] Acting Assistant Under Secretary for Health for Support (19), "URGENT: For Action: Fiscal Year 2025 Comprehensive Environment of Care Guidance (VIEWS 12437891)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 18, 2024.

[17] Office of the Chief Officer, Support Operations (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Compliance Report Survey (VIEWS 12688127)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), February 12, 2025.

Providers receive test results through view alerts (notifications) in the electronic health record system.[18] Due to the high volume of view alerts, providers may unintentionally overlook urgent, but noncritical test results, that require further action.[19] To address this risk, the Chief of Staff stated they worked with staff to only send alerts to providers when actions were required. These efforts helped reduce the average daily number of alerts per provider from approximately 300 to 200 over the previous year. In addition, the Chief of Staff explained that a clinical application coordinator sends data on alerts that providers have not acted on to the Chief of Staff and service chiefs every week so these leaders can address deficiencies with individual providers.

Action Plans and Process Improvements

The facility had no open recommendations from oversight reports related to communication of test results over the past three years. Leaders described how quality management staff track action plans, then monitor for sustained improvement and report this information to the Quality and Patient Safety Council and Executive Leadership Board.

Leaders described various ways staff identify improvement opportunities, including through the Joint Patient Safety Reporting system, peer reviews, hallway conversations, town halls, huddles, and leaders' visits to work areas.[20] Staff reported that executive and facility leaders support process improvement projects.

The OIG found that staff reviewed the quarterly External Peer Review Program data and noticed low scores in FY 2024 for providers communicating test results to patients within seven days from the time the result were available.[21] The Chief of Staff explained the program was limited in its ability to provide useful data because the sample size of the reviewed patient records was small and it did not provide real-time results.

In response, a clinical application coordinator, other facility staff, and VISN analysts developed two tracking tools (dashboards) to monitor test result communications for every patient. The tools monitor all test results rather than a limited sample and can generate immediate reports. Primary care staff initially piloted both tracking tools and they have since implemented them

[18] Department of Veterans Affairs, Office of Information & Technology (OIT), *Computerized Patient Record System (CPRS) User Guide: GUI Version*, October 2024.

[19] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, December 15, 2024, https://psnet.ahrq.gov/primer/alert-fatigue.

[20] The Joint Patient Safety Reporting (JPSR) system is used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023. A peer review "is a critical review of care performed by a peer." VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[21] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

facility-wide. Also in March 2025, staff implemented a software program (Clinisys) that automatically generates test result letters for patients.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities. Its mission is to ensure "every Veteran and family member has access to high value care where they need it, when they need it."[22] The OIG evaluated facilities' primary care and community care staffing, veterans' access to care, actions staff took to improve processes, and how leaders supported improvements. The OIG also examined actual and expected primary care panel sizes (number of veterans assigned to a care team) relative to VHA guidelines, and community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Primary care leaders told the OIG they are hiring new staff to fill vacant positions for one primary care provider and two registered nurses. In the interim, nurse practitioners cover vacant provider positions, and staff from other teams (clinics) cover the remaining vacancies. With VISN approval, leaders attempted to hire staff for the medical support assistant positions internally, but no qualified candidates applied. Subsequently, leaders said they moved medical support assistants from other areas to cover the work, but this practice would not be sustainable long-term. Staff stated the vacancies did not affect patients' access to care.

Staff also reported that primary care pharmacy services had two vacant positions, and two social workers covered 12 primary care teams. Although a social worker explained the workload is manageable and they have not delayed patient care, a pharmacy staff member said they felt overwhelmed. Primary care leaders explained that before January 2025, the facility employed many remote clinical pharmacists but lost a significant number of staff since the return to in-person work requirement. Leaders shared that they recently received approval to hire a new clinical pharmacist.

The OIG found panels averaged between 81 and 91 percent full from the third quarter of FY 2022 through the second quarter of FY 2025. Primary care leaders said their goal was 90 percent. Primary care staff said panel sizes are reasonable, and they could see established patients within three days. Additionally, each team dedicated two appointment slots per week for new patients to prevent delays.

[22] "Office of Integrated Veteran Care," Department of Veterans Affairs, accessed August 4, 2024, https://dvagov.sharepoint.com/sites/vhaoivc. (This website is not publicly accessible.)

Primary care leaders said they actively look for ways to improve efficiency and listen to staff's concerns during daily team huddles, online chats, and monthly meetings. For example, primary care leaders introduced a process where the patient stays in an exam room and pharmacy, nursing, social work, and medical support staff rotate in to see them, rather than the patient going to multiple different areas. Leaders reported these changes have improved collaboration and communication between primary care team members. Primary care staff agreed that the changes have improved clinical workflow.

Community Care Staffing and Access to Care

Community care leaders told the OIG that although the current organizational chart shows only three vacancies, the program lost seven staff members within the last year due to transfers and resignations, and they are unable to backfill them due to the hiring freeze. Additionally, community care leaders said executive leaders did not approve a new nurse case manager position because they felt the work could be completed by existing staff. However, nursing staff said the vacancies and administrative tasks have affected their ability to provide case management for complex patients and delayed the time it takes to schedule appointments or obtain records from community providers.

The medical support assistants stated their workload has increased due to vacancies, and they now review up to 3,000 referrals for community care per month, an increase of approximately 1000 referrals. To meet the demand, staff work overtime, and medical support assistant leads helped while also managing their own workload.

From January 1 through June 30, 2025, the OIG found it took community care staff an average of 3 days to initiate work on a referral and 24 days to schedule an appointment. Veterans waited an average of 70 days to be seen by a community provider. VHA's Office of Integrated Veteran Care states that staff must begin working on a referral within 2 business days of when it was entered, schedule appointments for veterans within 7 days, confirm veterans attended their appointment, and complete the referral within 90 days.[23]

Community care leaders said the facility's limited resources and rural location caused them to rely heavily on community partners to provide care to veterans. However, there are limited options for some services, and it can be a challenge for veterans to obtain timely care. For example, leaders said the facility does not offer urology, oncology, or some surgery services, and appointment wait times for veterans to receive community care for these services are from 81 to 89 days. Leaders said they are developing telehealth clinics to improve timeliness but are unable to expand community resources.

[23] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022; VHA Office of Integrated Veteran Care, chap. 4 in *Community Care Field Guidebook,* November 2022.

The OIG reviewed 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 aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[24]

During this inspection, VHA used three performance measures to determine the success of each facility's program. The first, HCHV5, measures the percentage of homeless veterans who receive a program intake assessment.[25] However, beginning in FY 2026, VHA no longer uses this as a performance measure. Next, HCHV1 measures the percentage of veterans who are discharged from contracted residential services and low-demand safe haven programs into permanent housing.[26] Finally, HCHV2 (negative exits), measures 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."[27]

Program Highlights

- The program met the HCHV5 and HCHV1 targets for FY 2024 and through the third quarter of FY 2025 but did not meet the HCHV2 target for the same time frame. Program staff said meeting the HCHV2 target is a challenge for the small, rural facility because several negative exits significantly affect the metric. In

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

[25] 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,* October 1, 2022; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures,* October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures,* November 2024.

[26] Low-demand safe havens are transitional residences with minimal restrictions for veterans with mental health or substance use issues. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[27] VHA sets targets for HCHV1 and HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

addition, some veterans choose to leave the program without securing permanent housing, which constitutes a negative exit.

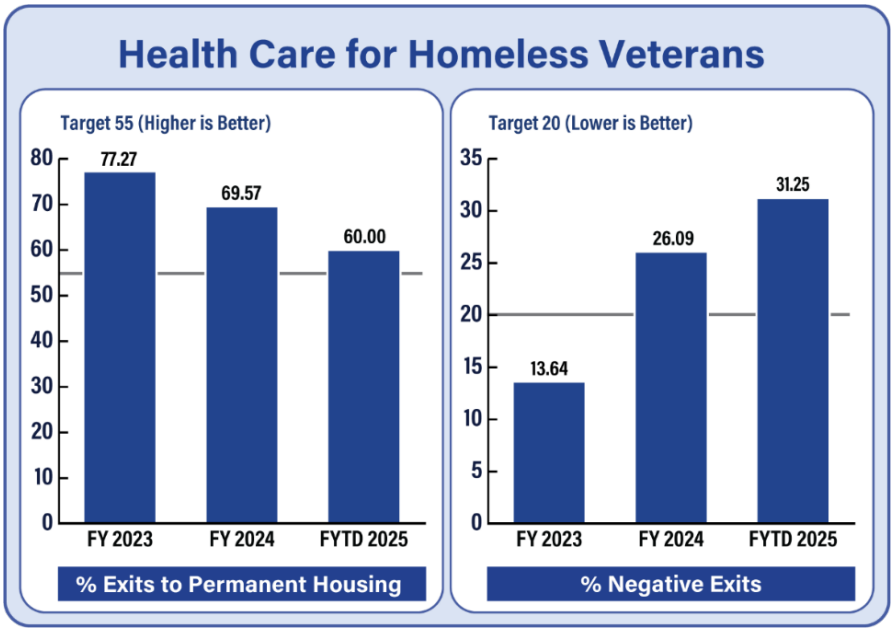

Figure 6. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.
FYTD = fiscal year to date.

- Staff explained they receive program referrals from a variety of sources, such as facility providers, community agencies, and veterans themselves. They conduct health fairs and outreach to assist veterans with the application process for VA health benefits. Staff also participate in twice-monthly collaboration calls with community partners and work closely with them to assist veterans with hotel stays, housing searches, rent and utility deposits, and furnishings.

Housing and Urban Development–Veterans Affairs Supportive Housing

The Housing and Urban Development–Veterans Affairs Supportive Housing program combines Department of Housing and Urban Development rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[28] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[29]

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

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[30]

Program Highlights

- The program did not meet the HMLS3 target in FY 2024 or through the third quarter of FY 2025.[31] The program coordinator said the facility has 156 allocated vouchers, with 115 currently assigned to veterans. The program manager stated the facility has too many vouchers because the community reached functional zero homelessness in 2018.[32] The coordinator said they requested to reallocate 20 vouchers to a public housing authority within a different VA medical facility's service area that needs them.
- The facility met the VASH3 target in FY 2024 and through the second quarter of FY 2025. The program manager said the community employment coordinator works with local employers to match veterans with suitable work.

Veterans Justice Program

VHA's Veterans Justice Program serves veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration.[33] Recognizing incarceration as a strong predictor of homelessness, the program focuses on connecting veterans to VA health care, services, and benefits. VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[34]

[30] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[31] For FY 2024, the facility was at 72.44 percent and 71.79 percent at the end of the second quarter of FY 2025.

[32] "A community has ended veteran homelessness when the number of veterans experiencing homelessness is less than the number of veterans a community has proven it can house in a month, with a minimum threshold of 3." "Talking About Functional Zero," Built for Zero Community Solutions, accessed February 13, 2025, https://login.builtforzero.org/functional-zero/.

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

[34] 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*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Program Highlights

- The program did not meet the target in FY 2024 or through the third quarter of FY 2025.[35] The program manager stated meeting the target is difficult because their VHA-set target is higher than the number of eligible veterans referred to the program.
- Program staff reported they receive 10 to 15 referrals per month from judges, probation officers, parole officers, and state and federal prison staff. They work with veterans at one regional jail, five state prisons, three federal prisons, and a veterans treatment court.[36]

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG did not make any recommendations following this inspection. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities.

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 appreciates the participation and cooperation of VHA staff during this inspection process.

[35] For 2024, the facility was at 94 percent and at 54 percent at the end of the third quarter of FY 2025.

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

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 voluntary questionnaires to employees through the facility's employee mail groups to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

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

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the panel discussions; the OIG asked for 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 July 7 through 10, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[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] 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.

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

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.

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: January 28, 2026

From: Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Facility Inspection of the VA Beckley Healthcare System in West Virginia

To: Director, Office of Healthcare Inspections (54HF02)

Chief Integrity and Compliance Officer (10OIC)

1. This memorandum is in response to the Office of Inspector General's (OIG's) draft report entitled—Healthcare Facility Inspection of the VA Beckley Healthcare System in West Virginia.
2. I have reviewed and concur with the findings and no recommendations.
3. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VA Capitol Health Care Network Office.

(Original signed by:)

Robert M. Walton, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: January 27, 2026

From: Director, VA Beckley Healthcare System (517)

Subj: Healthcare Facility Inspection of the VA Beckley Healthcare System in West Virginia

To: Director, VA Capitol Health Care Network (10N5)

Thank you for the opportunity to review the final report of the Office of Inspector General (OIG) Healthcare Facility Inspection of the VA Beckley Healthcare System in West Virginia. I have reviewed the document and concur with the findings and issuance of no recommendations.

The facility Chief of Quality Management will be available for additional information or assistance.

Thank you for the opportunity to continue strengthening our high-quality health care activities.

(Original signed by:)

George B. Drexel IV
Executive Director

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