US DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Tomah VA Health Care System in Wisconsin

Healthcare Facility Inspection | 25-00216-101 | April 16, 2026

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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 Tomah VA Health Care System (the facility) from August 25 through 28, 2025. The facility is rated as low complexity and, in fiscal year 2024, provided direct care to about 27,000 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal concerns or deficiencies that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated.

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[1] VHA classifies facilities based on their complexity level. Low complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through January," VHA Support Service Center, last updated February 17, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

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

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

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

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C). 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
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Executive Summary i

Abbreviations iii

Introduction 1

CULTURE 2

- System Shocks 3
- Employee Experiences 3
- Veteran Experiences 4

ENVIRONMENT OF CARE 4

- General Inspection 5

PATIENT SAFETY 5

- Communication of Urgent, Noncritical Test Results 5
- Action Plans and Process Improvements 6

INTEGRATED VETERAN CARE 6

- Primary Care Staffing and Access to Care 6
- Community Care Staffing and Access to Care 7

VETERAN-CENTERED SAFETY NET 7

- Health Care for Homeless Veterans 8
- Housing and Urban Development–Veterans Affairs Supportive Housing 9

Veterans Justice Program 10

Conclusion 11

Appendix A: Methodology 12

Appendix B: VISN Director Comments 14

Appendix C: Facility Director Comments 15

OIG Contact and Staff Acknowledgments 16

Report Distribution 17

Introduction

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

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

Culture: Culture is the system of shared values that shape an organization's behavioral norms; a positive culture is associated with better patient outcomes.[2]

Environment of Care: To ensure medical facilities are safe and clean, VHA established a comprehensive environment of care program.[3]

Patient Safety: VHA implemented patient safety programs to identify system vulnerabilities and reduce patient harm.[4]

Integrated Veteran Care: To promote positive health outcomes, VHA uses a multidisciplinary team-based approach for primary and community care services.[5]

Veteran-Centered Safety Net: VA serves as a coordinated national safety net for veterans, administering programs that offer medical care and social support services to vulnerable individuals, including those experiencing homelessness.[6]

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[1] "About VHA," Department of Veterans Affairs, last updated January 20, 2025, https://www.va.gov/aboutvha.

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

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

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

[5] VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025. VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

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

The Tomah VA Health Care System (the facility) includes a medical center in Tomah and four community-based outpatient clinics. In fiscal year (FY) 2024, the medical care budget was approximately $423 million. It had 21 hospital, 26 domiciliary, 128 community living center, and 10 compensated work therapy/transitional rehabilitation beds and served about 27,000 veterans.[7]

Figure 1. *Facility photo.*
Source: "VA Tomah Health Care," Department of Veterans Affairs, accessed January 17, 2026, https://www.va.gov/tomah-health-care/.

The OIG inspected the facility from August 25 through 28, 2025. The executive leaders referred to throughout this report include the Executive Director, Associate Director, Associate Director for Patient Care Services, and the acting Chief of Staff. The executive leaders have worked together since January 2025, when the acting Chief of Staff was detailed to the position.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances, system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[8] The OIG administered its own facility-wide questionnaire, reviewed VA's All Employee Survey results for October 1, 2021, through September 30, 2024, and Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their

[7] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, last updated May 1, 2025, https://www.va.gov/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," Department of Veterans Affairs, last updated June 3, 2025, https://www.va.gov/VA_CLC. Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," Department of Veterans Affairs, last updated October 13, 2021, https://www.va.gov/cwt. "Trip Pack - Operational Statistics Table FY2026 Through January," VHA Support Service Center, last updated February 17, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[8] 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.

level of trust in VA).[9] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[10]

System Shocks

Executive leaders described position vacancies, the return to in-person work order, and the upcoming new electronic health record implementation as systems shocks.[11] Leaders reported they lost approximately 14 employees during the first deferred resignation. They denied most employees who requested the second deferred resignation because of the need to maintain staffing levels.

When staff returned to in-person work, executive leaders developed a "Welcome" packet that included tips on parking, a facility map, and emergency procedures. In addition, staff received new sit-to-stand desks and ergonomic chairs to support workplace comfort and productivity.

***Figure 2.** Return to in-person work.*
Source: OIG interview with leaders and the "Welcome" packet.

VA plans to implement the new electronic health record in January 2027. Leaders told the OIG team that employees expressed anxiety and uncertainty about the change. In response, the Executive Director said they are gathering feedback from employees at other VA medical centers that have already implemented the new system.

Leaders said due to the return to in-person work requirement, they had to locate workspace at the main campus and convert training areas to workstations at the community-based outpatient clinics. Leaders recognized that some employees felt frustrated with having to travel to the main facility and are trying to address their requests to work closer to home.

Employee Experiences

Responses to the OIG questionnaire showed employees feel comfortable suggesting improvements to the work environment and reporting safety concerns. Almost half of the respondents identified stress and burnout as a top reason they would consider leaving the facility. Executive leaders acknowledged that employees are stressed at work and recognized their contributions to the facility and patient care. During town halls and meetings, leaders presented employees with the DAISY Award for honoring nurses who exhibit clinical excellence and compassionate patient care or the Good Catch Award for staff who report near misses of an

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[9] 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. The All Employee Survey was not administered in FY 2025; "Veteran Trust in VA," Department of Veterans Affairs, last updated January 20, 2026, https://www.va.gov/initiatives/veteran-trust-in-va/.

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

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

adverse patient event and unsafe conditions.[12] They also encouraged employees to participate in retreats, wellness challenges, and aromatherapy for rest and recovery.

Leaders also visited units and areas around the facility to engage with employees and hear their ideas. During these visits, employees suggested process improvements and requested items they need. For example, employees on one unit asked for a larger cart to bring equipment and paperwork to patients' rooms and transport their belongings during the discharge process. Leaders ordered the cart and reported that employees gave positive feedback.

Veteran Experiences

VSignals scores were consistently high, indicating that veterans trust the facility and have confidence in the care they receive. The Executive Director reported meeting with the chief experience officer every two weeks for updates on trends or concerns, especially issues the patient advocates could not resolve. Leaders assist with resolving those concerns, including contacting the veteran for follow-up. Leaders also stated they held town halls and met with veterans service organizations at least quarterly.[13]

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[14] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with the Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[15]

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[12] "What is THE DAISY Award?," The DAISY Foundation, accessed January 20, 2026, https://www.daisyfoundation.org; Naseema B. Merchant, et al., "Development of a Safety Awards Program at a Veterans Affairs Health Care System: A Quality Improvement Initiative," *Journal of Clinical Outcomes Management* 30, no. 1 (January/February 2023): 9-16, https://doi.org/10.12788/jcom.0120.

[13] "Veterans Service Organizations (VSOs) are organizations that aid and serve veterans, servicemembers, dependents, and survivors." Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

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

[15] 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

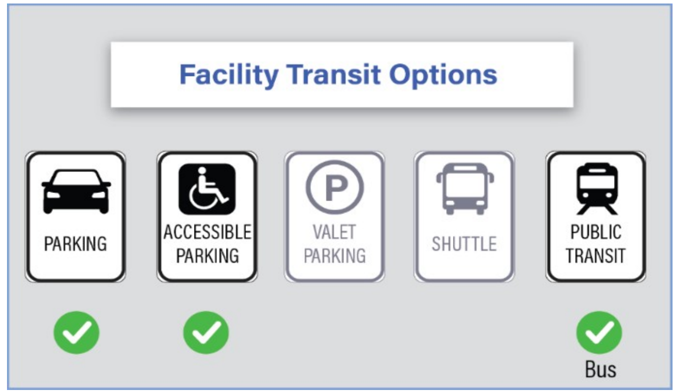

Figure 3. *Transit options for arriving at the facility.*
Source: OIG analysis of facility liaison questionnaire responses and supporting facility documents.

The team observed signs directing visitors at the facility entrance and throughout campus. The parking lots were well lit and had security cameras and police patrols. The main entrance had handheld maps, wheelchairs, and greeters ready to assist veterans and other visitors as needed. There were also snacks and drinks in the nearby urgent care clinic waiting room.

Doors had signs and the elevator panels inspected had braille markings. Facility documents described tools and resources available for hearing-impaired veterans, such handheld white boards for written communication, and amplified telephones. The facility also offers sign language services and hearing aid support services.

The OIG found patient care areas to be clean, with no privacy issues. Medical equipment had up-to-date inspection stickers, personal protective equipment was readily available, and contaminated medical waste was properly stored. In addition, medication and supply rooms were secure and contained no expired items.

PATIENT SAFETY

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.[16]

Communication of Urgent, Noncritical Test Results

The facility had processes to communicate urgent, noncritical abnormal test results to providers, to identify alternate care providers when the providers who ordered the tests were unavailable, and to convey results outside regular clinic hours. Leaders and quality management staff said the facility has processes to alert the providers to test results, including those from community providers. They also said the Chief of Staff and service chiefs receive weekly data from the clinical application coordinator on providers who have not acted on view alerts (messages that

[16] An examination of compliance with the communication of other types of test results was not within the scope of the inspection.

prompt a person to take action).[17] Facility leaders and employees review and discuss quarterly test results communication data to address potential concerns or delays.

Action Plans and Process Improvements

The facility had no open recommendations related to test result communications over the past three years. The chief of quality management said that when an oversight body makes a recommendation, staff monitor the action plans and ensure the improvements are sustained.

Leaders and quality management staff confirmed the facility uses multiple methods to identify improvement opportunities, including reviewing information from the Joint Patient Safety Reporting system, meetings, and patient safety visits throughout the facility.[18] Staff added that executive leaders support process improvement projects, and did not identify any barriers to initiating them.

INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[19] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines, and program effectiveness in increasing access to care.

Primary Care Staffing and Access to Care

At the time of the inspection in August 2025, the facility had vacancies for 11 providers, 2 licensed practical nurses, and 5 medical support associates. Primary care leaders have been continuously recruiting providers; however, they reported struggling to find qualified candidates. They said hiring in rural Wisconsin was challenging and only a limited number of providers are willing to relocate to the area.

Leaders also mentioned difficulties recruiting medical support associates due to lower salaries at the facility compared to the community. In response, leaders reported offering them retention incentives after being employed for 90 days.

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

[18] The Joint Patient Safety Reporting (JPSR) system is a database used as a collaborative tool for employees to document patient safety events including medical errors and close calls, and for the patient safety manager to track and trend reported events. VHA National Center for Patient Safety, *JPSR Guidebook*, *Version 6.0*, October 2025.

[19] "Community Care," Department of Veterans Affairs, last updated August 5, 2024, https://www.va.gov/communitycare.

Community Care Staffing and Access to Care

The OIG found the community care program had 32 administrative positions, which included 5 vacancies. Leaders said administrative staff were leaving their positions for more secure employment. The program also had 20 clinical staff members and no vacancies. Community care leaders reported no recruitment or retention issues related to clinical positions. Overall, community care staff said the workload is manageable and they did not identify the vacancies as affecting patient care.

Leaders also explained that community care teams mirror primary care teams, providing one point of contact for each teams' community care referrals. Both teams noted the success of this system and the ease with which they can collaborate.

The inspection team also reviewed community care data for the second quarter of FY 2025 and found staff averaged 15 days to schedule appointments, instead of the 7 days required by VHA's *Consult Timeliness Standard Operating Procedure*.[20] Leaders told the OIG that some scheduling delays were beyond their control. For example, if staff were unable to reach a veteran, they mailed a letter to the veteran to ask them to call to schedule an appointment within the next 14 days. However, the time frame exceeds the 7 days required. To improve scheduling timeliness, leaders said they worked with community care call center staff to help veterans schedule their appointments, so community care administrative staff can continue to process other referrals.

Community care leaders also discussed delays in care related to the limited availability of services in the community, particularly urology and cardiology. Leaders reported a 78-day and 55-day wait time for these services, respectively. In response, leaders partnered with another VA medical center to provide urology and cardiology care. The partnership provides veterans with transportation to the other VA medical center and priority scheduling for testing and consultation with the provider on the same day.

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

[20] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated June 12, 2025.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[21]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.[22] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[23] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (referred to as negative exits).[24]

Performance and Improvement Highlights

- Program staff noted the facility met the intake assessment target (HCHV5) in FY 2024 because facility staff received referrals from multiple programs and reported strong connections with community partners. The facility program is

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

[22] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. 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.

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

[24] VHA sets targets for 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.*

exempt from the HCHV1 and HCHV2 measures because it does not have contracted emergency residential services or low-demand safe haven beds.

- Through responses to its questionnaire, the inspection team learned that program staff conduct outreach to veterans experiencing homelessness through local agencies, including shelters and veteran programs across several counties, to identify and enroll them in the program. Staff also present at veteran town halls and Stand Down events.[25]

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[26] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[27]

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 in the program who are employed (performance measure VASH3).[28]

Program staff requested that the housing authority extend a voucher and secure a special housing rate for a veteran with a spinal cord injury and family members with special needs. Staff also collaborated with a landlord to locate a rental home and ensure the installation of specialized equipment to meet the veteran's needs.

***Figure 4.** Best practice.*
Source: OIG analysis of a questionnaire response and interview with program staff.

Performance and Improvement Highlights

- According to the OIG's data analytics and facility program leaders and staff interviewed, the program did not meet the facility-assigned housing voucher target in FY 2024 due to low demand for vouchers in the local area. Facility program leaders said the program originally had 100 vouchers, but in 2023, they returned 30 vouchers due to nonuse.

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[25] "Stand Downs are typically one- to three-day events during which VA staff and volunteers provide food, clothing and health screenings to homeless and at-risk Veterans." "VA Homeless Programs, Stand Down Events," Department of Veterans Affairs, last updated February 24, 2026, https://www.va.gov/homeless/events.

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

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

[28] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

- Program leaders also said their staff educated property managers about the program, which resulted in a property manager providing veterans with 13 units at one location. Facility program staff said landlords will now reach out to them first when a unit becomes available.
- The program met the program participant employment target in FY 2024. A program leader attributed the success to active collaboration with local business owners and vocational rehabilitation staff to support veterans seeking employment. The facility program has an employment specialist who assists veterans with seeking alternative income sources, such as Social Security.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[29] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[30]

Performance and Improvement Highlights

- The facility's program did not meet the target for enrollees for FY 2024, which facility program staff attributed to limited staffing. They reported that the addition of a team member in early 2025 allowed them to distribute their workload across four staff in total and enroll more veterans.
- Staff receive program referrals from various sources and conduct outreach at the library, Veterans Service Office, jails, prisons, and veterans treatment courts. They also work with court personnel to help identify veterans on court dockets and in jails who may benefit from establishing care at the facility.
- Program staff also recognize that some enrolled veterans need housing assistance, so they work closely with the HUD-VASH program to help them secure permanent housing.

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

[30] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures.*

Conclusion

To assist leaders in evaluating the quality of care at the Tomah facility, the OIG conducted an inspection across five domains. Based on overall positive findings, the OIG did not make any recommendations for corrective action. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed 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 all employees through the facility's employee mail groups to gain insights and perspectives on the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The 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 support reviews of inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[3]

Potential limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

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[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.

Healthcare Facility Inspection program directors selected inspection sites and OIG leaders approved them. The team inspected the facility from August 25 through 28, 2025. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

In the absence of current VA or VHA policy, the OIG considers 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 16, 2026

From: Network Director, Veterans Integrated Service Network (VISN) 12 (10N12)

Subj: Healthcare Facility Inspection of the Tomah VA Health Care System in Wisconsin

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report, Healthcare Facility Inspection of the Tomah VA Health Care System. I concur with the findings and issuance of no recommendations.
2. I would like to thank the OIG inspection team for their review of the Tomah VA Health Care System.

(Original signed by:)

Daniel S. Zomchek, Ph.D.
Network Director, VISN 12

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: March 9, 2026

From: Director, Tomah VA Health Care System (676)

Subj: Healthcare Facility Inspection of the Tomah VA Health Care System in Wisconsin

To: Director, VISN 12: VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review and provide a response to the draft report of the Healthcare Facility Inspection of the Tomah VA Health Care System in Wisconsin. I have reviewed the document and concur with the findings and issuance of no recommendations.
2. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Karen Long, MSN, RN
Executive Director

OIG Contact and Staff Acknowledgments

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