US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Wichita Healthcare System in Kansas

Healthcare Facility Inspection	25-00250-210	August 7, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Wichita Healthcare System (the facility) from July 29 through 31, 2025. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to about 29,000 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

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG found the facility did not have workflows that describe team members' roles in the process for communicating test results, and staff did not monitor data on communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made two associated recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.

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[1] VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized 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 February," VHA Support Service Center, accessed April 1, 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] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

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

- **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. The OIG made no recommendations.

What the OIG Recommended

1. The Medical Center Director develops service-level workflows for communicating test results.
2. The Medical Center Director monitors data on the communication of test results to providers and patients as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The interim Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C). The OIG continued communication with VHA regarding the findings, which resulted in the closure of recommendation 1. For the open recommendation, the OIG will follow up on the planned actions until they are completed.

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Abbreviations

ADPCS	Associate Director of Patient Care Services
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

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.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[6]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[7]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[8]

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

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[9]

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

[6] 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.

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

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

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

The VA Wichita Healthcare System (the facility) opened in 1933. The OIG team inspected the facility from July 29 through 31, 2025. At the time of the site visit, the facility had 41 hospital, 40 community living center, and 10 domiciliary beds.[10]

Figure 1. *Facility photo.*
Source: "VA Wichita Health Care," VA, accessed August 13, 2025, https://www.va.gov/wichita-health-care.

The executive leaders referred to throughout this report include the Medical Center Director (Director), acting Associate Medical Center Director, Chief of Staff, Associate Director of Patient Care Services (ADPCS), and Assistant Medical Center Director. The facility liaison reported the newest member of the team was the Director, assigned in 2023; the Chief of Staff had been in place since August 2021; and the ADPCS had served the longest, since August 2018.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

[10] A community living center is also referred to as a VA nursing home "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed April 1, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[11] 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.

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

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

System Shocks

Executive leaders identified several recent events that disrupted operations and negatively affected employees' morale. These included a severe rainstorm on June 3, 2025, that caused flooding, and operational changes responsive to executive orders and memorandums in January 2025 such as the mandatory return to in-person work and hiring freeze (in effect from January 20, 2025, to October 15, 2025).[14]

The rainstorm occurred in the afternoon, affecting patients at the facility or traveling to it. The floods affected parking lots, building entryways, hallways, and some inpatient rooms. According to the Director, facility leaders implemented the incident command structure used in response to emergencies. Employees acted immediately to support one another. For example, nurses helped the Environmental Sanitation Service remove water in flooded areas, and employees gave towels to patients who entered the building wet from the rain. According to the acting Associate Medical Center Director, employees relocated patients to unaffected inpatient rooms or waiting areas. Facility police directed patients and employees so they could safely leave the facility and get to their cars.

After the incident, facility leaders replaced sheetrock and ceiling tiles, placed concrete in some areas to keep water away from buildings and basements, and provided the OIG with evidence of a contract to fix roof leaks. They also cleaned storm sewers and drains regularly to remove obstructions and worked with the city of Wichita to improve the drainage system.[15]

At the time of the site visit in July 2025, executive leaders stated that some employees were concerned about the return to in-person work requirement and hiring freeze. The acting Associate Medical Center Director also stated that because of the hiring freeze, they could not backfill certain vacancies. Leaders responded by reassigning employees to those areas with the greatest need to manage the increased workload.

The Director also described Chat and Chew meetings (virtual meetings during lunch, when employees could ask questions and raise concerns) as one of the leaders' best tools for addressing issues. Additionally, leaders said they conducted weekly rounds (regular visits to

[14] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025); Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

[15] A facility leader reported that the east side would still be at risk of flash flooding because the facility was located between two major drainage systems in the city.

departments to proactively identify issues and take corrective actions) to acknowledge employees' successes and address concerns.

Employee Experiences

Most OIG questionnaire respondents indicated that executive leaders' communications were clear, useful, and frequent. Executive leaders reported they believed most employees viewed the facility as an employer of choice and were highly engaged and satisfied. The ADPCS stated the VA Office of Nursing Services recognized the facility as one of the highest ranked for nurse satisfaction and asked leaders to share best practices on how they keep the workforce engaged.

Additionally, most OIG questionnaire respondents reported they feel comfortable reporting concerns and suggesting actions to improve their work environment. The ADPCS explained the importance of facility leaders modeling psychological safety.[16] For example, they used the VHA Just Culture Decision Tool for staff to discuss various patient safety incidents and collaborated on any corrective actions.[17] Additionally, the Chief of Staff reported that leaders empower employees to identify and participate in process improvement activities.

Veteran Experiences

Patient advocates' responses to the OIG questionnaire indicated executive leaders were responsive to veterans' concerns. Veterans' requests to change providers were the top concerns patient advocates received for the first six months of FY 2025. The Chief of Staff attributed this to some veterans disagreeing with their provider about their need for narcotic prescriptions (drugs used to treat pain).[18] The chief said the prevalence of these concerns were related to a VHA initiative to reduce narcotic use. Leaders approved provider changes and offered alternative options to manage pain for some veterans.

The ADPCS explained that inpatient satisfaction notably improved over the previous three years. The leader attributed this to better discharge processes, which help ensure staff effectively communicate instructions following release. By sitting when talking to veterans, staff also show interest and more effectively establish a connection.

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[16] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[17] The VHA Just Culture Decision Tool provides a nonpunitive process for determining the organization's response to a patient safety event through guidance to identify whether an event was caused by "human error, at-risk behavior, reckless behavior, malicious action or impaired judgement." It also gives response options for each of the potential causes. VA National Center for Patient Safety, "Just Culture Framework," (fact sheet), April 2025.

[18] *Merriam-Webster*, "Narcotic," last updated March 12, 2026, https://www.merriam-webster.com/narcotic.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[19] 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.[20]

General Inspection

On arrival, the OIG team found signs to parking lots with accessible spaces for veterans with disabilities, emergency call buttons, and a shuttle service. There was also a public bus route that included a stop at the facility. However, there were no signs to direct veterans to the main entrance from the parking lot for those who are unfamiliar with the campus.

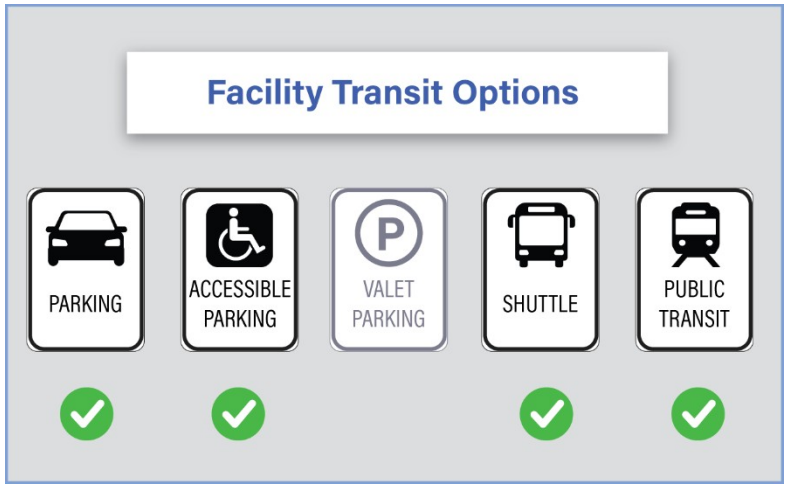

Figure 2. *Transit options for arriving at the facility.*
Source: Documents provided by the facility liaison, questionnaires, and OIG observations.

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

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

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: Documents provided by the facility liaison, questionnaires, and OIG observations.

The main entrance appeared well-maintained and had volunteers and printed maps available at the information desk. However, the facility did not have wall maps at the main entrance, and maps located in other areas of the facility were small and used small print, which made them difficult to follow.

Staff and volunteers reported assisting veterans with visual and hearing impairments, which was consistent with responses to an OIG questionnaire. Braille was available on elevator signs, tactile warnings were installed on walking surfaces, and closed captioning was available on televisions. The deputy quality manager reported that personal amplifiers were available for veterans who were hearing impaired, and veterans received a pocket card identifying them as sensory-impaired for use at the facility and in the community. Volunteers and staff were available to escort veterans to appointments. Front desk staff and volunteers were not trained in sign language but used handwritten notes and personal escorts to assist veterans when needed.

PATIENT SAFETY

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

Communication of Urgent but Noncritical Test Results

The facility did not have service-level workflows that describe team members' roles in the process to communicate test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[21] Both the Chief of Staff and associate chief of primary care acknowledged the facility did not meet the requirement.

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

Recommendation 1

The Medical Center Director develops service-level workflows for communicating test results.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Medical Center has completed the corrective action to address this recommendation. The Communication of Test Results Policy was revised by the Quality Manager, in collaboration by the clinical service chiefs, to include standardized service-level workflows outlining the process and responsibilities for communicating test results to patients. The revised policy was reviewed and approved by the Medical Center Director (MCD) and published on the medical center SharePoint site on June 23, 2026, making it readily accessible to all staff.

OIG Comments

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

Additionally, the OIG noted that staff did not monitor data on communications of test results, as required by VHA Directive 1088(1). The chief of quality management reported that staff began monitoring the data one month prior to the OIG's site visit in July 2025, but they were unable to provide documents to support this statement.

Recommendation 2

The Medical Center Director monitors data on the communication of test results to providers and patients as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__ Concur

____ Nonconcur

Target date for completion: July 1, 2027

Director Comments

The facility Quality Manager has an established process for monitoring compliance of Communication of Test Results (CTR). Since July 2025, Quality Management (QM) staff

have conducted monthly audits of abnormal or non-critical Communication of Test Results documentation to evaluate compliance with VHA Directive 1088(1) requirements. Audit results are analyzed and presented to the Quality Patient Safety Council (QPSC) and subsequently reported to the facility Governing Board through the established governance oversight process.

QM staff communicate audit findings, including identified gaps, documentation deficiencies, and other instances of noncompliance, directly to the responsible Licensed Independent Providers (LIPs) and the applicable clinical service leadership for review and corrective action. Service Chiefs and clinical supervisors are responsible for addressing identified deficiencies through provider feedback, education, and implementation of service-specific corrective actions as needed. To further support implementation of the revised Communication of Test Results Policy effective June 23, 2026, Quality Management will continue to conduct monthly audits of a minimum of 50 outpatient medical records to assess compliance with VHA Directive 1088(1).

Compliance Standard: Quality Management will aggregate the monthly audits for quarterly reporting to the Quality Patient Safety Council. Reporting on compliance will be done until 90% compliance is met for two consecutive quarters. The numerator will be the total number of abnormal or non-critical test results communicated in compliance with VHA Directive 1088(1). The denominator will be the total number of abnormal or non-critical test results reviewed.

OIG Comments

The OIG will follow up on the planned actions until they are completed.

Action Plans and Process Improvements

Facility leaders shared various practices they used to identify opportunities for process improvement. For example, the patient safety manager said staff typically identify trends through a daily review of events that staff enter in the Joint Patient Safety Reporting system.[22] The patient safety manager also told the OIG team that staff report repeated events in an email to executive leaders. From interviews, the OIG learned that risk management, patient safety, and systems redesign staff work collaboratively on process improvements.

[22] 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.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[23] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

A facility document showed 12 vacancies across the 31 primary care teams as of July 2025–four providers, two licensed practical nurses, and six medical support assistants. The chief of primary care stated that at least five additional providers were considering retirement. The Chief of Staff described offering incentive bonuses, increasing pay, and starting recruitment for anticipated vacancies six to nine months in advance to maintain adequate staffing levels.

The Code of Federal Regulations, title 38, section 17.4040 states that patients may be referred to community providers if the primary care wait time is greater than 20 days.[24] The OIG found that in FY 2024, new primary care patients received appointments in an average of 17.7 days, and established patients were scheduled within 2.1 days. To further reduce wait times, the Chief of Staff added a primary care team and, by the end of July 2025, established patients' wait times had dropped to 1.4 days.

Community Care Staffing and Access to Care

The chief of community care reported vacancies for one licensed independent practitioner; one assistant nurse manager; two advanced medical support assistants; and one administrative position, such as a supervisory program support specialist or health system specialist.[25] Due to the inability to backfill positions at that time, the chief of community care continued managing previous responsibilities while assuming the new leadership role, which began about one month prior to the OIG's July 2025 visit.

Facility community care staff's responses to an OIG questionnaire indicated the top three concerns as increased workload, missing medical documents from community providers, and

[23] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

[24] 38 C.F.R. § 17.4040 (2025).

[25] "A licensed independent practitioner (LIP) is an individual permitted by law and the VA medical facility through its medical staff bylaws to provide patient care services independently, without supervision or direction, within the scope of the individual's license and in accordance with privileges granted by the VA medical facility." VHA Directive 1100.20(2), *Credentialing of Health Care Providers*, September 15, 2021, amended September 11, 2024.

inadequate community care administrative staffing. The community care nurse manager reported that community care referrals have increased by 10 percent each year.

The OIG found that community care staff scheduled appointments on an average of 11 days. However, VHA's *Consult Timeliness Standard Operating Procedure* requires staff to schedule appointments within 7 days of the referral's entry into the patient's health record.[26] Community care staff reported that reduced staffing levels negatively affected the timeliness of scheduling.

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. At the time of the OIG inspection in July 2025, FY 2024 was the most current complete fiscal year data available for these performance measures.

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.[27]

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 veterans who received an HCHV program intake assessment.[28] 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) and low-demand safe haven programs (transitional residences with

[26] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated October 2, 2025.

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

[28] 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.

minimal restrictions for veterans with mental health or substance use issues).[29] 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)."[30]

Performance and Improvement Highlights

- The facility exceeded the program intake (HCHV5) target for FY 2024. The facility's homeless program supervisor said staff began coordinating outreach activities with community partners, which helped them locate veterans and enroll them in the program.
- The supervisor said program staff exceeded the permanent housing (HCHV1) target for FY 2024 because they referred veterans in the contract emergency residential services program to the HUD-VASH program for placements. Contract staff also more accurately documented veterans' discharge status (staff errors were made previously in recording the type of discharge), which helped them stay below the negative discharge (HCHV2) ceiling target.
- Program staff said they participated in a housing event with landlords and other community partners with the goal of quickly housing veterans, many of whom already had vouchers or other supportive resources. According to the HCHV outreach social worker, a few veterans received permanent housing through the event the same day.

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

[29] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 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.

[30] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures.*

illness, physical health diagnoses, and substance use disorders."[31] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[32]

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).[33]

Performance and Improvement Highlights

- The facility missed the voucher use (HMLS3) target for FY 2024. The supervisor reported believing the program was on track to meet the target in FY 2024 but received an additional 60 vouchers during this fiscal year, which were difficult to use by the end of the year.
- The supervisor cited not meeting the employment (VASH3) target for FY 2024 due to data discrepancies caused in part by staff documentation errors, such as veterans listed as unemployed who could not work because of a disability.
- The program lead case manager reported it was a challenge to help veterans obtain documents needed for permanent housing, such as identification cards, Social Security cards, and birth certificates. The lead case manager said it was also a challenge to locate housing options for aging veterans who were no longer able to live independently.

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.[34] 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).[35]

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

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

[33] 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 2024 Homeless Performance Measures.*

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

[35] 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 2024 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility exceeded the enrollment (VJP1) target for FY 2024. The program supervisor reported hiring one outreach staff member in FY 2024 and another in FY 2025.
- The supervisor said they worked closely with jail staff, collaborated with veterans' defense attorneys, and enrolled veterans into case management services.
- Another staff member described working with a veterans treatment court, which they found effective.[36] In one case with positive outcomes, a veteran enrolled in the treatment court program reconnected with family and received mental health services.

Conclusion

To assist leaders in evaluating the quality of care at the Wichita facility, the OIG conducted an inspection across five domains. The OIG made two recommendations related to improving communications of medical test results to patients and providers. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 1. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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.

[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

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[37] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from July 29 through 31, 2025. 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 inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[38] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[39]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[40] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[37] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

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

[39] 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.

[40] 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 directors selected inspection sites and OIG leaders approved them. 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 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[41] 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.

[41] 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: July 1, 2026

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Facility Inspection of the VA Wichita Healthcare System in Kansas

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

Attached is the facilities response to the VA Wichita Healthcare System in Kansas draft report.

I have reviewed and concur with the facility's response to the findings, recommendations, and submitted action plans.

(Original signed by:)

Ahmad Batrash, MD, FACP
VISN 15 Interim Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 1, 2026

From: Director, VA Wichita Healthcare System (589)

Subj: Healthcare Facility Inspection of the VA Wichita Healthcare System in Kansas

To: Director, VA Heartland Network (10N15)

We appreciate the opportunity to work with the Office of Inspector General (OIG), Office of Healthcare Inspections, as we continuously strive to improve the quality and safety of health care provided to our Nation's Veterans. We are committed to ensuring Veterans receive high-quality care that reflects the principles, values, and pillars of High Reliability Organization practices.

In response to the findings of the OIG Healthcare Facility Inspection review, the facility has developed and implemented action plans to address each of the recommendations. I have reviewed the findings, recommendations, and the facility's proposed corrective actions and concur with the response as submitted. The facility is committed to completing all action plans and ensuring their sustainment through ongoing monitoring and oversight.

Thank you for the opportunity to respond to the draft report. Should you require additional information, please contact the Veterans Integrated Services Network Quality Management Officer.

(Original signed by:)

Michael D. Payne Jr., MSP, CLSSBB, ACHE
Medical Center 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.