US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Lebanon Healthcare System in Pennsylvania

Healthcare Facility Inspection	**25-00259-250**	**August 26, 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.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

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 Lebanon Healthcare System (the facility) from December 1 through 4, 2025. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to approximately 51,000 veterans.[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 issues 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 have recently been incarcerated.

[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 FY2025 Through September," VHA Support Service Center, last updated April 6, 2026, https://reports.vssc.med.va.gov/TripPackOperationalStatisticsTable. (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 (2018).

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.[4]

DAVID C. KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

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

Abbreviations

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

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 has programs to 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]

---

[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 Lebanon Healthcare System (the facility) serves veterans across nine counties in south central Pennsylvania. It includes a medical center in Lebanon and community-based outpatient clinics in Lancaster, Mechanicsburg, Pottsville, Reading, and York. In fiscal year (FY) 2025, the facility's medical care budget was over $794.3 million; it had 49 inpatient hospital, 43 domiciliary, 12 compensated work therapy, and 76 community living center beds and served approximately 51,000 veterans.[10]

Figure 1. *Facility photo.*
Source: "VA Lebanon Health Care," VA, accessed October 7, 2025, https://www.va.gov/lebanon-health-care.

The OIG team inspected the facility from December 1 through 4, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), acting Associate Director, Chief of Staff, acting Assistant Director, and acting Associate Director for Patient Care Services.

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

[10] 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. 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," VA, last updated June 15, 2026, https://department.va.gov/cwt. 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/clc. "Trip Pack - Operational Statistics Table FY2025 Through September," VHA Support Service Center, last updated April 6, 2026, https://reports.vssc.med.va.gov/TripPackOperationalStatisticsTable. (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.

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]

System Shocks

Executive leaders identified several system shocks at the time of the December 2025 inspection. These included a January 2025 deferred resignation program, which placed participating facility staff on paid administrative leave through September 2025 (when they voluntarily ended their federal employment) as well as voluntary early retirements. Collectively these programs resulted in vacancies that could not be filled during the hiring freeze (in effect from January 20, 2025, to October 15, 2025).[14] Floods in the sterile processing department were also identified as a system shock.

Over a short period in FY 2025, the logistics department lost 30 percent of its workforce—including employees in key supply and inventory management positions—due to deferred resignations and early retirements. In response, executive leaders met daily with the chiefs of the Logistics and Operations services, reviewed clinical service needs, identified staffing gaps, and discussed mitigation strategies. Leaders cross-trained employees from other departments to unpack and stock supplies; supervisors assumed extra duties; and executive leaders worked alongside frontline employees to meet the demand. At the time of the December 2025 interview, leaders had filled all but three supply and inventory management positions.

When describing the floods, leaders shared that in July 2025 engineers working in a bathroom above the sterile processing service struck a pipe, which quickly flooded an equipment area. The engineers stopped the water flow; then environmental management service, engineering, and sterile processing employees contained the flooding to the cart wash area. Leaders activated an incident command center to work together and check in every four hours for the following three days until the area was operational again. Leaders emphasized that employees showed exceptional teamwork and minimized impacts to patient care.

---

[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.

[14] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 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.

Employee Experiences

Responses to the OIG questionnaire indicated that employees stay at the facility because of the VA mission, pay and benefits, and overall job satisfaction. Most respondents reported feeling comfortable reporting patient care or safety concerns and empowered to suggest cultural improvements, reflecting psychological safety.[15]

The OIG team reviewed documents that showed facility leaders invested in the employee experience through initiatives such as VA Voices (a staff training program focused on building veteran trust and staff engagement through storytelling and better connecting employee values to the VA mission); Whole Health (a program that helps develop individualized health plans); and visits to work areas that link leaders to frontline employees.[16] The 12-month Lebanon Leadership Program—open to all employees—develops high-potential individuals for leadership roles, and aligns with the facility's 2025 strategic goals to improve veterans' experiences, enhance employee engagement, and support a culture of safety. In 2024, the facility received 40 applications and selected 12 participants; in 2025, it received 53 applications and selected 15 participants.

Veteran Experiences

VSignals and Survey of Healthcare Experience of Patients scores, which measure patient satisfaction, both exceeded national averages.[17] Patient advocates reported in an OIG questionnaire that staff are responsive to veterans' concerns and veterans can give direct feedback to facility leaders. Executive leaders acknowledged transportation as a common complaint. To meet this need, they provided options to veterans such as rideshare services that reinforce their commitment to veteran-centered care.

Additionally, the Veteran Advisory Council meets quarterly with veterans service organizations and congressional representatives to share information about the facility and discuss veteran-

[15] "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.

[16] "Whole Health," VA, accessed February 13, 2025, https://www.va.gov/wholehealth; National Center for Organization Development, "VA Voices - Building Care through Better Relationships," Employee Engagement Newsletter, October 2019.

[17] "Veterans Health Administration Hospital Performance Data," Centers for Medicare & Medicaid Services, last updated September 10, 2024, https://www.cms.gov/-Instruments/HospitalQuality/VA-Data.

related concerns.[18] Leaders reported the facility earned the VA's Best Patient Experience Award, acknowledging its commitment to trustworthy veteran care.[19]

Attention to environmental design improves veterans' and staff's safety and experience.[20] 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 team examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[21]

General Inspection

The facility had directional signs posted at the entrance and throughout the site. The parking lots had ample spots, including spaces accessible for those with mobility issues; they were also well-lit and had security cameras and police patrols.

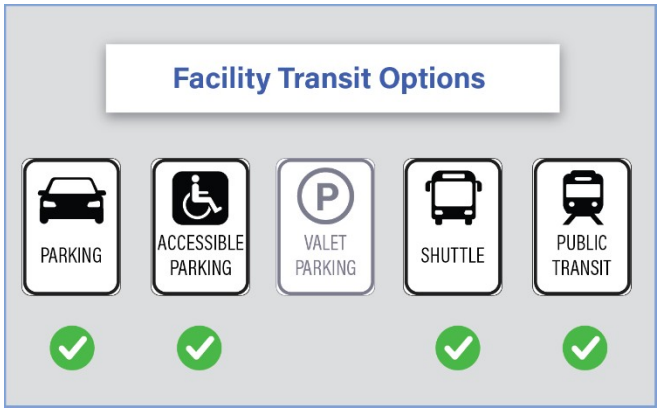

Figure 2. *Transit options for arriving at the facility. Source: Facility liaison questionnaire response, team observations, facility policy MCP 138-11, and facility and parking maps.*

The main entrance was being renovated, so staff had established a temporary entrance nearby. At the entrance, the team observed a large automatic door that opened into a vestibule, where veterans could wait for transportation. A desk was directly in front of the door, where staff and volunteers provided information, directions, and assistance as

[18] "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.

[19] VA, "VA Announces Winners of the 2025 Veterans Health Administration Patient Experience Awards," news release, March 30, 2026, https://news.va.gov/145873/2025-patient-experience-awards.

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

[21] 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.

needed. The inspection team noted clinic and office directories posted in hallways, near elevators, and on walls throughout the facility.

Patient care areas and the community living center areas were clean. Medical equipment had current inspection stickers, and staff protected patient privacy. Personal protective equipment was readily available, and contaminated medical waste was properly stored in a locked area with restricted access. Medication and supply rooms were secure and contained no expired medications or supplies. The team found the community living center welcoming and bright, and staff offered enriching activities for residents. The team observed a loose floor tile and missing pull cords for nurse call alarms. Staff corrected these issues during the inspection, so the OIG did not make a recommendation for corrective action.

Additionally, the team reviewed facility documents that identified damage in fire and smoke barriers, and improper chemical and gas cylinders storage.[22] However, the team did not observe any of these issues remaining or recurring during the inspection.

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

Communication of Urgent but Noncritical Test Results

The facility's Medical Center Policy 20-37, *Communicating Test Results to Provider and Patients* had processes to communicate abnormal test results to providers and patients, assign a surrogate (designee) when a provider is unavailable or has left the facility, communicate results outside regular clinic hours, and manage transitions between care settings.[23] Additionally, the policy included service-level workflows, which describe staff members' roles and responsibilities.

However, the external peer review program coordinator identified that staff did not always meet the requirement set forth in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* to communicate abnormal test results to patients within seven days, although the

[22] Previous oversight reports included the Annual Facility Evaluation, Lebanon *VAMC [VA medical center] Survey, March 31-April 4, 2025*; The Joint Commission, *Final Accreditation Report Lebanon VA Medical Center*, July 11-14, 2023; and Ascellon, *Department of Veterans Affairs Community Living Center Survey Report*, *May 6-9, 2025*. (These reports are not publicly accessible.)

[23] Lebanon VA Medical Center, MCP [Medical Center Policy] 20-37, *Communicating Test Results to Provider and Patients*, June 1, 2025.

facility did achieve compliance in the fourth quarter of FY 2025.[24] The coordinator acknowledged that providers often waited until the patient's next appointment to communicate their test results. To improve timeliness with test result communications, the coordinator audited electronic health record information weekly, reported findings to oversight committees, and trained primary care and surgical staff. The coordinator reported these efforts had been effective.

In June 2025, the chief of informatics implemented a new standardized process for providers to document and track long-term follow-up orders and set up self-reminders to enter the order in the electronic health record system. The goal is to reduce missed follow-ups and delayed diagnoses, enhancing patient safety and clinical efficiency. Although the program was new and staff were still evaluating its effectiveness, the Chief of Staff reported positive feedback at the time of the inspection in December 2025.

Action Plans and Process Improvements

The facility had no open recommendations related to the communication of test results. Quality management staff reported they tracked action plans to completion, monitored sustainment, and reported the information to an oversight committee.

Leaders and staff also described various methods they used to identify opportunities for improvement, including the Joint Patient Safety Reporting system and patient safety forum discussions. Additionally, quality management staff met daily with executive leaders to discuss patient safety trends and events to identify improvement opportunities. Leaders discussed patient safety concerns in various meetings and during visits to work areas throughout the facility. Clinical areas also have performance improvement boards for staff to identify, develop, and implement initiatives to enhance patient care.

As part of the patient safety forum, the patient safety manager developed a patient safety escape room interactive activity to increase awareness of reporting processes. Participants worked together to solve clues that reinforced key safety concepts, such as timeliness and accuracy of reporting concerns, and encouraged a culture of proactive reporting of incidents as well as conditions that pose a risk of harm to patients.

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

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[25] The OIG evaluated facilities' primary care and community care staffing, 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

Facility documents showed multiple vacancies within primary care at the time of the inspection in December 2025. A primary care employee reported that providers left due to overall workload demands and difficulty obtaining approved leave. Float (temporary) providers maintain care continuity by covering teams with provider vacancies.

Primary care leaders stated they were actively recruiting providers and licensed practical nurses, which are the hardest positions to fill because the facility cannot compete with higher private-sector salaries. However, they were not recruiting medical support assistants. Instead, medical support assistants performed dual roles covering both primary care and specialty care clinics, which is inconsistent with the VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* staffing ratio requirement for primary care teams (one provider to one registered nurse, one licensed practical nurse, and one medical support assistant).[26] As noted above, the facility was actively working to recruit primary care employees; therefore, the OIG made no recommendation for corrective action.

The OIG found that 6 of 36 primary care panels (patients assigned to a care team) exceeded the baseline capacity of 1,200 patients for providers, as recommended by VHA Directive 1406(3), *Patient Centered Management Modules (PCMM) for Primary Care*.[27] In an interview, the Chief of Staff stated their ideal panel size is 85 to 95 percent of capacity. One primary care provider reported arriving early to prepare for clinic days and expressed concern to the inspection team that continued panel growth could negatively affect patient care. The chief of primary care attempted to provide time to complete non-direct patient care tasks (administrative time), but

[25] "Community Care," VA, last updated June 16, 2026, https://department.va.gov/vha/community-care; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

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

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

acknowledged the time was limited and providers worked extra hours to keep up with the workload.

The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time for a VA facility is greater than 20 days.[28] The facility's appointment wait times for new patients averaged about 18 days between October 1, 2024, and June 30, 2025, and established patients' wait times averaged around 3 days during the same period. Additionally, primary care staff noted an increased number of new patient appointments since August 2025, following a facility outreach initiative. As of June 2026, the average wait time for a new patient appointment was 21 days.

Community Care Staffing and Access to Care

Leaders reported one registered nurse and four medical support assistant vacancies in community care, which they attributed to the Return to In-Person work memorandum.[29] At the time of the December 2025 inspection, three positions were in the hiring process, and two were pending approval.

The OIG team found there were 36,332 referrals made for community care in FY 2025, an increase of 5,437 from the prior year, due in part to several specialty care provider vacancies within the facility. Community care nurses provide care coordination for patients with moderate and complex needs. Care coordination involves reviewing a patient's medical record, ensuring the patient is aware of their community appointments and any required follow-up treatment, reviewing after-care notes from the community provider, and relaying information on to the provider. A nurse manager reported that nurses review more than 30 medical records a day and are responsible for care coordination until each episode of care is complete. However, nurses reported they lack the time to provide thorough care coordination due to the volume of referrals. The nurse manager confirmed the nurses struggle to meet these expectations. Due to the facility's hiring efforts mentioned earlier, the OIG did not make a recommendation for further action.

The team also found that community care staff scheduled appointments within 17 days, although VHA's *Consult Timeliness Standard Operating Procedure* sets a 7-day standard.[30] Facility documents also showed that as of November 24, 2025, 219 medical documents were pending review beyond the facility's 5-day target. Leaders could not comment on the nature of the

[28] 38 C.F.R. § 17.4040 (2025).

[29] "Heads of all departments and agencies in the executive branch of Government shall, as soon as practicable, take all necessary steps to terminate remote work arrangements and require employees to return to work in-person at their respective duty stations on a full-time basis, provided that the department and agency heads shall make exemptions they deem necessary." Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

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

medical documents because they had not been reviewed. Leaders stated they have been offering overtime to staff to ensure they review the pending medical documents.

Facility community care leaders also told the OIG they received serious complaints from veterans related to quality and safety of care issues they experienced with some community care providers. Leaders reported they followed protocol to report the complaints to the third-party administrator (an external company that manages the contracts with community providers) but at the time of this inspection in December 2025, had not received any responses. The OIG inspection team referred this finding to another directorate within VA OIG for further evaluation.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[31]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted 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).[32] HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply

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

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

with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[33]

Performance and Improvement Highlights

- The facility's program met the permanent housing (HCHV1) target for FY 2025 but missed the negative exit (HCHV2) target. Program staff attributed success with meeting the permanent housing target to reinforcing goals with veterans and preparing them for independence. Staff noted some challenges with meeting the negative exit target. They worked with the contract staff to provide lower restrictions for veterans and offer case management services to prevent negative exits. Staff also reported the facility has many contracts with community partners that provide beds across multiple sites; however, only one site can accommodate women and families.
- Staff collaborate with facility partners to identify veterans experiencing homelessness through weekly meetings with domiciliary staff and primary care social workers, as well as quarterly meetings and case consultations with geriatrics and extended care staff.

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."[34] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[35]

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).[36]

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

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

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

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

Performance and Improvement Highlights

- The facility's program met both the voucher use (HMLS3) and employment (VASH3) targets in FY 2025, which staff attributed to collaborations with community partners to identify and support veterans' housing needs.
- Program leaders reported having 544 vouchers assigned for FY 2026 and at the time of the December 2025 inspection, 472 were in use.
- Staff work in teams that focus on specific geographic sections of the service area. This approach helps them connect with the community and access available resources.

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.[37] 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).[38]

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target for FY 2025, which staff attributed to strong connections with local jail liaisons, who provide names of recently arrested veterans.
- Program staff said they work with nine jails and participate in five veteran treatment courts, which are judicially supervised, multi-phase treatment programs.[39]

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

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

[39] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Staff are also responsible for assisting veterans at all federal and state prisons in the Veterans Integrated Service Network.[40]

- Staff worked with local lawyers as well to support veterans with additional legal issues, such as writing wills.

Conclusion

To assist leaders in evaluating the quality of care at the VA Lebanon Healthcare System, the OIG conducted an inspection across five domains. The OIG made no recommendations. 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.

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

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. The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from December 1 through 4, 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.

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.[41] 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.*[42]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[43] 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[44] The OIG reviews available evidence within a

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

[42] 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.

[43] 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.

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

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.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 4, 2026

From: Director, VISN 1

Subj: Healthcare Facility Inspection of the VA Lebanon Healthcare System in Pennsylvania

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

Chief Integrity and Compliance Officer (10OIC)

I have reviewed the VA OIG Draft Report: Healthcare Facility Inspection of the VA Lebanon Healthcare System in Pennsylvania. I am in concurrence with the draft report and facility responses provided.

(Original signed by:)

Ryan Lilly, MPA
Veterans Integrated Service Network 1 Director, VHA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 28, 2026

From: Director, VA Lebanon Healthcare System (595)

Subj: Healthcare Facility Inspection of the VA Lebanon Healthcare System in Pennsylvania

To: Director, VISN 1 (10N1)

1. We appreciate the opportunity to review and comment on the OIG draft report– Healthcare Facility Inspection of the VA Lebanon Healthcare System in Pennsylvania. VA Lebanon Healthcare System concurs with the report.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management Service.

   I acknowledge receipt of this letter.

   (Original signed by:)

   Jeffrey Beiler, II
   Director, Lebanon VA Medical Center

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Joanne Wasko, MSW, LCSW, Director Jennifer Nalley, AuD, Team Leader Bruce Barnes Rose Griggs, MSW, LCSW
Other Contributors	Dianna Amick, MBA, BSN Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Sheeba Keneth, MSN/CNL, RN Simon Kim, PhD Hanna Lin, MSA, LCSW Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Office of Accountability and Whistleblower Protection
Office of Public and Intergovernmental Affairs
Office of General Counsel
Office of Congressional and Legislative Affairs
Director, VISN 1
Director, VA Lebanon Healthcare System (595)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate: John Fetterman, Dave McCormick
US House of Representatives: Madeleine Dean, Chrissy Houlahan, John Joyce, Daniel Meuser, Scott Perry, Lloyd Smucker

OIG reports are available at www.vaoig.gov.

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.