US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Northern Arizona VA Health Care System in Prescott

Healthcare Facility Inspection	26-00052-251	August 26, 2026

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

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Executive Summary

The 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 Northern Arizona VA Health Care System (the facility) from January 13 through 15, 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 31,800 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 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. 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 March 5, 2026, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (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.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The VA Health Service Area Director and facility Director concurred with the report (see appendixes B and C). No further action is required.

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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

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.[4] 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.[5]

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.[6]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[7]

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.[8]

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

[5] 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.

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

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

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

The Northern Arizona VA Health Care System (the facility) includes the Bob Stump VA Medical Center, which opened in 1939, in Prescott and 11 community-based outpatient clinics.[9] The facility is rated as *low complexity* and in fiscal year (FY) 2025, provided direct care to about 31,800 patients.[10] The facility's medical care budget for FY 2025 was approximately $550 million, and it had 15 hospital, 120 domiciliary, and 75 community living center beds.[11]

The OIG team inspected the facility from January 13 through 15, 2026. The executive leaders referred to throughout this report include the Director; Associate Director; Associate Director for Patient Care Services; Deputy Associate Director for Patient Care Services; and Chief of Staff.

Figure 1. *Bob Stump VA Medical Center. Source: "VA Northern Arizona Health Care," VA, accessed March 5, 2026, https://www.va.gov/northern-arizona-health-care.*

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.[12] 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

[9] The facility's community-based outpatient clinics are in Anthem, Chinle, Cottonwood, Flagstaff, Holbrook, Kayenta, Kingman, Lake Havasu City, Page, Polacca, and Tuba City, Arizona.

[10] 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 March 5, 2026, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (This web page is not publicly accessible.)

[11] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv. 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.

[12] 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).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

System Shocks

In the OIG questionnaire and interviews, executive leaders and the quality and patient safety chief reported that a power outage in August 2024—caused by a surge in the city's electric grid—disrupted veteran care and strained critical systems, including refrigeration and climate control. The surge damaged a transformer, which prevented the emergency electrical system from supplying power to all areas of the facility, and required replacement equipment to stabilize the system. Rising temperatures in the facility posed a threat to medications and laboratory equipment, which prompted executive leaders to obtain emergency cooling equipment to maintain safe conditions.

During the six-day outage, executive leaders set up an incident command center (a standardized organizational structure to manage operations during an emergency), and communicated with veterans, employees, and congressional staff through emails, meetings, and social media posts. Additionally, executive leaders canceled outpatient appointments, halted admissions, closed the emergency department to ambulances, and transferred three veterans to another VA medical center. Power was restored and the facility's electrical systems functioned as expected. The Director acknowledged that the facility's electrical system was undergoing further electrical evaluations and infrastructure upgrades to prevent an outage from occurring again.

Employee Experiences

Employee respondents to the OIG questionnaire indicated concerns about the direction of the facility's culture, but about half were comfortable suggesting actions to improve their work setting, as shown in figure 2. Still, more than a third were uncomfortable doing so. The Director believed employees answered in this manner because the questionnaire was distributed at the same time as the December 2025 announcement of VHA's reorganization plan, which caused uncertainty about job security—a key component of facility culture.[15] Further, the Chief of Staff reported that the start of employees' concerns about their employment seemed related to the deferred resignation program (which incentivized resignations from federal employment).[16]

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

[14] 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/HEALTH/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[15] VA, "VA Launches Veterans Health Administration Reorganization," news release, December 15, 2025, https://news.va.gov/press-room/va-launches-veterans-health-administration-reorganization.

[16] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025.

Despite the answers about the direction of the facility's culture, about 71 percent of respondents to the OIG questionnaire said they felt comfortable reporting a safety concern.

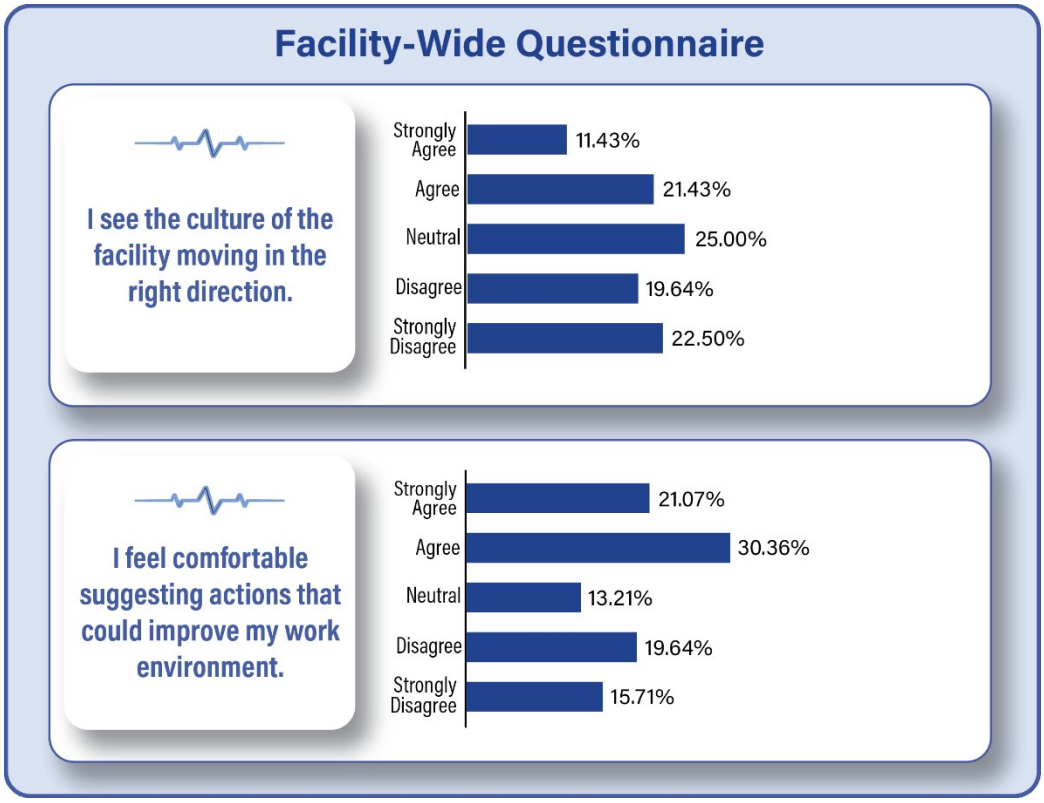

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

To improve employees' experiences and promote transparency, leaders implemented monthly forums (when employees' questions set the agenda); town halls; weekly emails; and wellness initiatives, such as walking competitions and access to gardens where employees grow flowers and vegetables. Leaders also met individually with employees to respond to specific questions and needs, and they reported positive feedback on these actions. The Director acknowledged that some employees disagreed with responses provided in the forums or with subsequent actions but emphasized the primary goal was to ensure transparent decision-making. Most OIG questionnaire respondents indicated that leaders' communications were clear, frequent, and useful.

Veteran Experiences

The OIG team examined VSignals scores from FY 2024 through most of FY 2025 and found that 95–96 percent of veterans trusted the facility to meet their needs for outpatient care. These scores exceeded the VHA average, as shown in figure 3.

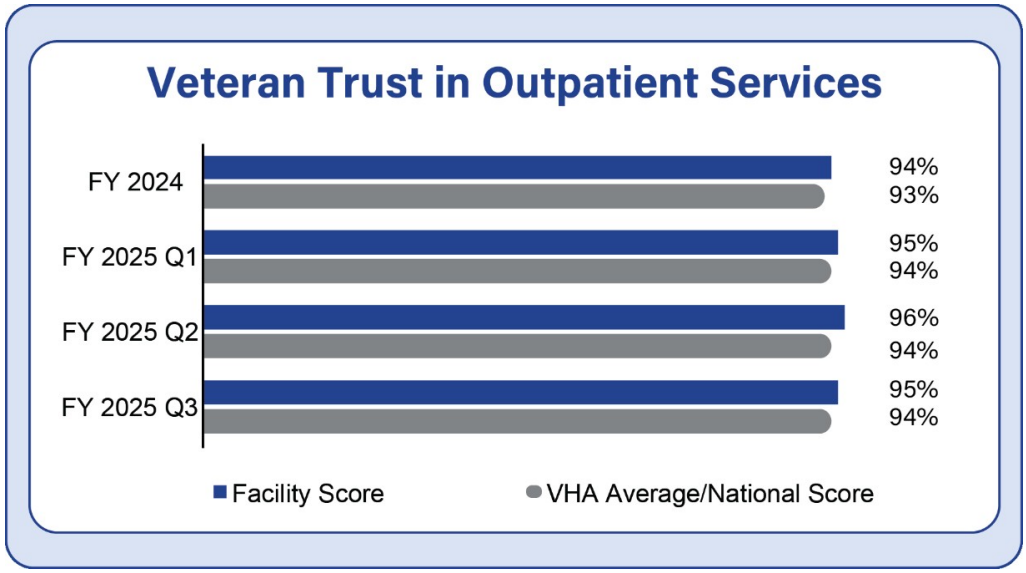

Figure 3. *Veteran trust in outpatient services.*
Source: VSignals data.

The Director credited these scores to weekly emails sent to all employees with veterans' comments and suggestions for improvement. The Director also identified several innovative services the facility offers. For example, audiology employees provided caption glasses (which display spoken words) to a hearing-impaired Korean War veteran while the technology was in its testing phases. The facility was also one of 10 nationwide artificial intelligence test sites for a service that allows clinicians to spend more time interacting with veterans and less time documenting in the patients' electronic health record. The Chief of Staff said early feedback on the artificial intelligence was positive.

In the OIG questionnaire, a patient advocate reported that veterans frequently complained about changes to their community care eligibility for additional chiropractic care, acupuncture, and massage therapy appointments.[17] Specifically, the Director clarified eligibility for visits in the community because facility employees' approvals of community providers' requests to add more appointments were inconsistent due to a lack of specific guidance. Now the facility regularly requires documentation from the community provider showing why more visits are needed. With

[17] 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 change, the facility followed the VHA requirement that community providers submit medical documentation after veterans' appointments.[18]

The patient advocate and clinical leaders also created a facility standard operating procedure, *Procedure for Review of Community Care Request for Service for Chiropractic Care, Acupuncture, Massage Therapy*, which outlines employee responsibilities when a community provider requests an extension of these services.[19] Additionally, executive leaders communicated the changes to veterans through emails and quarterly meetings with congressional representatives. Once veterans understood the new guidance, no complaints escalated beyond the clinical leaders.

ENVIRONMENT OF CARE

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 inspectors 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]

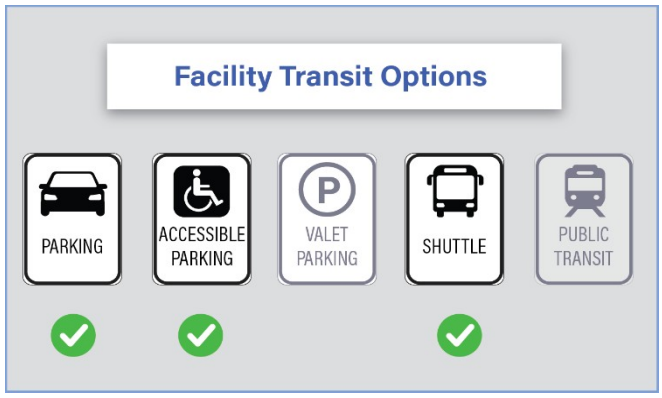

Figure 4. *Transit options for arriving at the facility. Source: OIG team observations.*

General Inspection

The OIG team observed covered drop-off areas, shuttle stops that help patients access the facility, and adequate parking. There

[18] VA, "Medical Document Submission Requirements for Care Coordination" (fact sheet), May 5, 2021, https://www.va.gov/CommunityCare/factsheets/FactSheet_27-02.pdf.

[19] Northern Arizona VA Health Care System, "Procedure for Review of Community Care Request for Service for Chiropractic Care, Acupuncture, Massage Therapy" (standard operating procedure), May 5, 2025.

[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.

was no public transit to the facility, however, and no valet parking. Inspectors also noted directory signs included clinics that had been relocated, and temporary signs that listed access hours but not alternate entrances used for when the doors are locked. VHA Directive 1850.05, *Interior Design Program* requires the facility's interior designer to maintain a comprehensive signage and wayfinding program.[22] Inaccurate signs can cause patients to get lost or delayed, which may lead to missed appointments or increased stress. The Associate Director explained that clinics were relocated to create additional workspace after staff returned to in-person work but they had not updated the signs. Because the OIG confirmed that staff were working to correct the signs, no recommendation for further action was made.

During a general inspection, the OIG team observed the facility was clean and well-maintained. The team did not identify any patient safety or privacy concerns as well.

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 OIG team found that the facility had processes for providers to

- notify the providers who order tests of urgent but noncritical test results,
- follow up with patients,
- assign an alternate provider when the providers who order tests are unavailable or have left the facility, and
- transmit results outside regular clinic hours and during care transitions.

The facility also had service-level workflows that define the roles of team members in communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[23] Quality management staff stated they review data from the External Peer Review Program to determine whether patients received notification of results that require action within seven days, as detailed in the directive. The facility's data showed 100 percent compliance with this requirement in FY 2025.

[22] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023.

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

Action Plans and Process Improvements

There were no findings in the previous OIG comprehensive healthcare inspection report published in 2023 related to test result communications.[24] In an interview, facility leaders said improvement activities usually start with action plans based on oversight recommendations and incidents that staff report to the patient safety database. The patient safety manager explained that staff investigate the incidents, implement corrective actions, and track the actions to determine if they improve patient safety.

Through incident reports, facility leaders identified prolonged delays in receiving results from VHA's national teleradiology program. However, they reported no adverse outcomes from the delays. In December 2025, they developed a standard operating procedure, *Contingency Procedure for Prolonged Delays in Teleradiology Turnaround Times*, for a new process that allows the clinician to ask an on-call facility radiologist to read the image if the report from the national program radiologist exceeded four hours.[25]

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[26] 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

In January 2026, primary care leaders reported that workload was affected by 10 vacancies (4 providers, 4 registered nurses, and 2 medical support assistants) across 42 teams. Facility leaders were actively recruiting for the positions with incentives, such as education loan repayment and special salary rates.

In an interview, leaders told the OIG they took the following actions to maintain patient care:

- Used Clinical Resource Hub providers (a team of healthcare professionals who work at different VA facilities) and other temporary staff to cover vacancies

[24] VA OIG, *Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System in Prescott*, Report Number 22-00052-121, May 23, 2023.

[25] Northern Arizona VA Health Care System, "Contingency Procedure for Prolonged Delays in Teleradiology Turnaround Times" (standard operating procedure), December 2025.

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

- Assigned registered nurses to teams with no licensed practical nurse
- Temporarily closed the Holbrook and Polacca clinics and provided care through telehealth and community providers[27]

Despite staffing challenges, new patient appointment wait times for the first three quarters of FY 2025 remained under 20 days. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[28]

Community Care Staffing and Access to Care

At the time of the inspection in January 2026, the program had vacancies for one supervisory administrative assistant and 15 medical support assistants. Community care leaders attributed these vacancies to retirements, the return-to-work requirement, and the hiring freeze (in effect from January 20, 2025, to October 15, 2025).[29] Leaders reported actively recruiting medical support assistants and had extended offers to three candidates. To cover vacancies, medical support assistants worked with additional teams and leaders offered voluntary overtime.

In the third quarter of FY 2025, staff most frequently referred veterans to community providers for radiology, optometry, and cardiology. Community care program leaders told the OIG team the facility offered some of these services, but the demand for care exceeded capacity.

As of December 2025, the OIG team found that staff took an average of 16 days to schedule the appointments. However, VHA's *Consult Timeliness Standard Operating Procedure* directs program staff to schedule appointments within 7 days after a provider refers a patient for community care.[30] Community care leaders attributed the scheduling delays to vacancies, the high volume of referrals, and limited number of some specialty care providers in the community.

Community care leaders said staff referred veterans to other VA facilities if they could provide the care needed. Community care staff also contacted veterans with referrals and discussed wait times for VA and community providers to help them make informed decisions about when and

[27] "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

[28] 38 C.F.R. § 17.4040 (2025).

[29] 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.

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

where to receive care. Leaders stated these efforts redirected 2,649 referrals to other VA facilities with availability, which saved $6,530,555 in community care expenditures during FY 2025. The OIG did not make a recommendation about scheduling timeliness because leaders were already taking the actions noted above.

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 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)."[33]

[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.

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

Performance and Improvement Highlights

- The facility's program met the exit to permanent housing (HCHV1) target for FY 2025. Program staff attributed this success to the availability of HUD-VASH vouchers and contracted emergency residential services staff who helped veterans transition to stable housing.
- Program staff credited meeting the negative exit (HCHV2) target for FY 2025 to strong relationships with contracted emergency residential services staff and daily engagement with veterans. Facility program staff educated the residential staff on reengaging veterans who broke rules instead of discharging them from the program, which helped maintain continuity of care.
- Facility program staff conducted outreach at campsites, shelters, and community partners' agencies, and during stand downs (community events where veterans can get free services) and point-in-time counts (estimates of the size of the homeless population).[34] The program's dedicated primary care team attended these events and provided basic healthcare services.
- However, program staff reported some barriers to meeting veterans' needs. Long travel times to rural areas and remote encampments made locating and engaging veterans difficult. Many veterans chose these areas to avoid populated areas, which required long-term outreach to build trust and rapport.

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."[35] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[36]

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

[34] VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022; "VA Homeless Programs, Point-in-Time (PIT) Count," VA, accessed May 30, 2023, https://department.va.gov/homeless/pit-count.

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

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[37]

Performance and Improvement Highlights

- The facility's program fell short of the voucher use (HMLS3) target for FY 2024, which program staff attributed to their vacancies. It met the target in FY 2025. Staff reported five positions were filled during FY 2024, and three more in early 2025, which helped improve performance. The program provides housing for veterans in a building that offers 48 units for voucher holders, where staff maintain a daily presence to support residents.
- The program did not meet the employment (VASH3) target for FY 2024 but achieved it in FY 2025. Staff attributed earlier shortfalls to vocational development specialist vacancies, but leaders filled these positions in February 2024 and January 2025. These specialists educated other program staff on employment resources, assisted veterans with résumés, provided transportation, and secured clothing suitable to wear on interviews.
- Through community partnerships, staff also helped veterans access transportation, budgeting advice, utility assistance, food banks, and senior centers to reduce isolation. They organized community outings and coordinated medical and mental health care. Program staff also partner with VHA facilities in Albuquerque, New Mexico, and Phoenix, Arizona, for veterans who reside closer to those facilities.

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.[38] 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).[39]

[37] 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.*

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

[39] 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.*

Performance and Improvement Highlights

- Facility program staff reported meeting the enrollment (VJP1) target for FY 2025 by increasing outreach to tribal and community partners, distributing information sheets during outreach events, and educating stakeholders, community partners, and facility staff on the benefits of the program.
- Staff supported veterans in eight treatment courts by assessing their needs and coordinating mental health and substance use services with facility staff and community partners.[40] Staff tracked progress; reported outcomes to the courts; and helped resolve minor legal issues, such as warrants and traffic violations, during stand downs.

Conclusion

To assist leaders in evaluating the quality of care at the Northern Arizona VA Health Care System, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. 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] "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. 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 staff to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from January 13 through 15, 2026. 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: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: July 13, 2026

From: Health Service Area 5.3 Director, VISN 5

Subj: OIG Draft Report-Health Care Facility Inspection of the Northern Arizona VA Health Care System in Prescott

To: Director, Office of Healthcare Inspections (54HF01)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report-Health Care Facility Inspection of the Northern Arizona VA Health Care System in Prescott. I have completed a full review of the draft report.
2. I concur with the report, which included no recommendations.
3. Please contact the VISN 5-Health Service Area 5.3 Quality Management Officer for questions or if additional information is needed.

(Original signed by:)

Walt Dannenberg, FACHE
VISN 5 – Health Service Area 5.3 Director
Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 10, 2026

From: Steven J. Sample, MS, FACHE, CHC, Executive Director, Northern Arizona VA Health Care System (NAVAHCS)

Subj: VA OIG Draft Report: Healthcare Facility Inspection of the Northern Arizona VA Health Care System in Prescott

To: Director, Desert Pacific Healthcare Network (10N22)

I would like to extend our sincere appreciation to the Office of Inspector General for your time, expertise, and collaboration during our Healthcare Facility Inspection (HFI) Program review. Your insights and thorough evaluation are invaluable in helping us strengthen our practices, improve patient safety, and uphold the highest standards of quality within our organization.

Thank you again for your continued partnership and professionalism.

(Original signed by:)

Steven J. Sample, MS, FACHE, CHC
Executive Director

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