



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the William S. Middleton Memorial Veterans Hospital and Clinics in Madison, Wisconsin

Healthcare Facility
Inspection

25-00254-277

September 30, 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 William S. Middleton Memorial Veterans Hospital and Clinics (the facility) from September 22 through 25, 2025. In April and September 2026, the inspection team requested an update from the facility. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 42,000 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 facility's policy for communicating test results did not contain all necessary elements, and leaders had not developed workflows that describe staff members' roles in the communication process for each service, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.³ The OIG made two recommendations.

¹ VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, "Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) William S. Middleton Memorial Veterans' Hospital," last updated February 13, 2026.

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.

- **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.
- **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. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate action so staff update the facility's test result communication policy to align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
2. The Chief of Staff and Associate Director for Patient Care Services develop workflows that describe staff members' roles in the process of communicating 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 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 for the full text of the directors' comments).⁵ The OIG will follow up on the planned actions until they are completed.



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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.

⁵ 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 Networks (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

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Introduction

The Office of Inspector General (OIG), 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.⁶ 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.⁷



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.⁸



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.⁹



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.¹⁰

⁶ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁷ 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>.

⁸ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

⁹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The William S. Middleton Memorial Veterans Hospital and Clinics (the facility) includes a community living center and seven community-based outpatient clinics in Illinois and Wisconsin.¹¹ It is affiliated with and physically connected to the University of Wisconsin School of Medicine and Public Health. In addition to lung, heart, and liver transplant programs, the facility is one of four regional VA Epilepsy Centers of Excellence in the Northwest region.¹²



Figure 1. Facility photo.

Source: “William S. Middleton Memorial Veterans’ Hospital,” VA, accessed January 28, 2026, <https://www.va.gov/madison-health-care/locations>.

The facility provides outpatient services to around 42,000 veterans and in fiscal year (FY) 2025, it had an operating budget of approximately \$695 million.¹³ It had 118 beds distributed across acute hospital care, the community living center, and the compensated work therapy-transitional residence.¹⁴

The OIG team inspected the facility from September 22 through 25, 2025, and requested an update from the facility in April and September 2026. The executive leaders referred to throughout this report include the Executive Director (Director), Associate Director, Chief of Staff, Associate Director for Patient Care Services, and Assistant Director. The Associate Director and Assistant Director had the shortest tenures, being permanently assigned in January and July 2024, respectively. At the time of the inspection, the leaders had worked together for less than one year.

¹¹ 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 VA Epilepsy Centers of Excellence consists of 19 facilities that provide “comprehensive epilepsy evaluation and care for Veterans with seizure disorders.” “Epilepsy Centers of Excellence (ECoE),” VA, last updated October 3, 2025, <https://www.epilepsy.va.gov>.

¹³ VA, “Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) William S. Middleton Memorial Veterans’ Hospital,” last updated February 13, 2026.

¹⁴ 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 October 13, 2021, <https://www.va.gov/cwt>. VA, “Facility Trip Pack (VISN 12) William S. Middleton Memorial Veterans’ Hospital.”



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.¹⁵ 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).¹⁶ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁷

System Shocks

Many OIG questionnaire respondents identified changes to the federal workforce in FY 2025—the return to in-person work, anticipated reductions in force (layoffs), the deferred resignation program, and the elimination of labor unions and the Diversity, Equity, and Inclusion office—as major system shocks.¹⁸ Executive leaders acknowledged these changes disrupted their ability to focus on routine responsibilities and reduced employees’ morale and trust in leaders.

Leaders explained the requirement for in-person work significantly affected facility operations. Prior to the requirement, over 700 employees teleworked, which minimized parking limitations and helped with recruitment and retention. Leaders stated it was difficult to find enough office space to accommodate the employees. To create over 100 new workspaces, a Space Committee and Relocation Work Group repurposed conference rooms and shared areas. The committee and work group also organized a welcome back event to boost employee morale.

Leaders said the threat of a reduction in force created uncertainty, particularly for probationary employees, and contributed to feelings of disrespect. In addition, leaders and OIG questionnaire

¹⁵ 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>.

¹⁶ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁷ 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.

¹⁸ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Implementing the President’s “Department of Government Efficiency” Workforce Optimization Initiative, 90 Fed. Reg. 9669 (Feb. 14, 2025). The deferred resignation program offered employees the option to resign from federal service and retain their pay and benefits through September 2025. “Original Email to Employees,” Office of Personnel Management, accessed October 7, 2025, <https://www.opm.gov/about-us/fork/original-email-to-employees>. Exclusions From Federal Labor-Management Relations Programs, 90 Fed. Reg. 14553 (Apr. 3, 2025); VA, “VA Terminates Union Contracts for Most Bargaining-Unit Employees,” August 6, 2025, <https://news.va.gov/press-room/va-terminates-union-contracts>; Ending Radical and Wasteful Government DEI [diversity, equity, and inclusion] Programs and Preferencing, 90 Fed. Reg. 8339 (Jan. 29, 2025).

respondents stated the loss of union representation was difficult for employees because of the perceived loss of rights and protections. Leaders also reported that dissolving the Diversity, Equity, and Inclusion office caused employee distress. To maintain transparency and reduce the effects of these changes, leaders held weekly town halls, issued regular briefings, and used an internal website to collect and answer questions in real time. In September 2026, the facility reported that national VA hiring restrictions have been lifted—allowing recruitment and onboarding efforts to move forward. The facility has accommodated its staff with available workspace. Leaders partner with services across the facility to optimize work areas and ensure that operational requirements and employee needs are met.

Employee Experiences

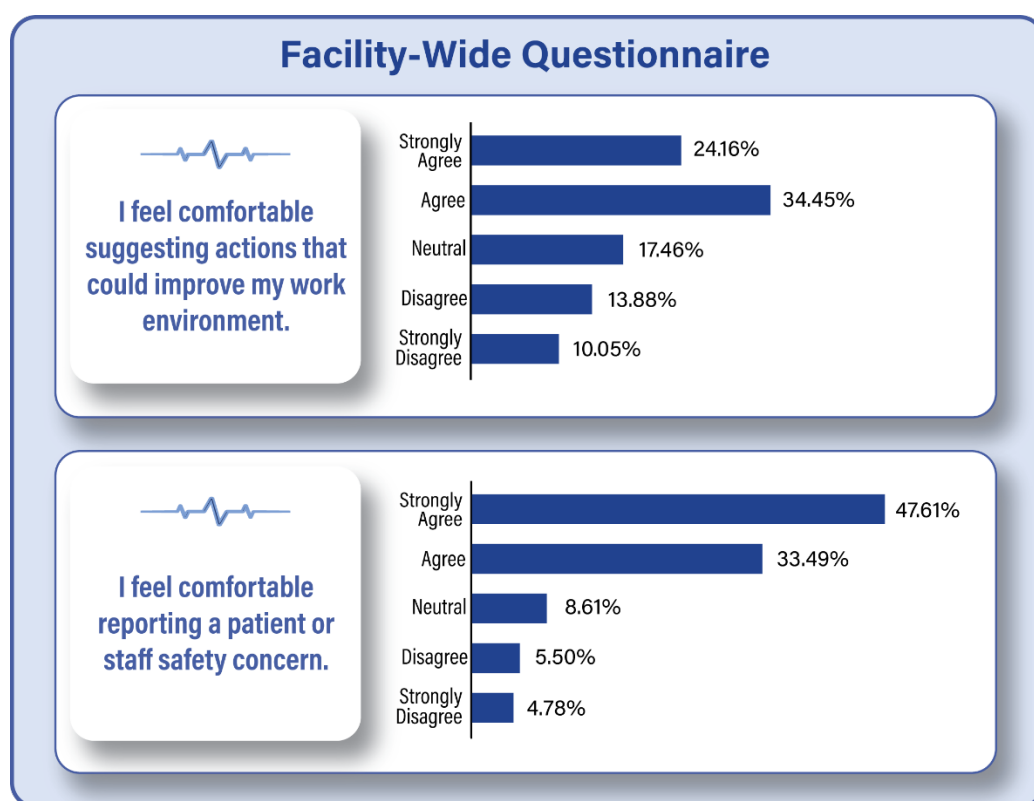


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

Approximately 59 percent of respondents to the OIG questionnaire indicated they felt comfortable suggesting actions that could improve their work environment, and more than 80 percent noted they felt comfortable reporting safety concerns, as shown in figure 2. Executive leaders attributed these positive results to the facility’s High Reliability Organization efforts,

which began in 2019.¹⁹ They explained that employees feel safe reporting concerns because leaders focus on improving systems rather than assigning individual blame. Leaders also said they display patient safety metrics on huddle boards (electronic boards in service areas used by employees to track and escalate issues to leaders) and added a safety concern button on the facility's internal website for employees to report issues.

OIG questionnaire respondents cited the VA mission as their primary reason for working at the facility. Leaders agreed that employees are deeply committed to serving veterans. However, some respondents indicated they considered leaving due to stress, burnout, and concerns about recent organizational changes, as discussed previously. To improve the employee experience, leaders held monthly recognition ceremonies and provided opportunities for employees to propose innovative projects. They emphasized the importance of being approachable and relational—whether through informal hallway conversations or attending team-building events such as picnics and holiday celebrations.

Most OIG questionnaire respondents also reported that executive leaders had improved their communication practices. Respondents described executive leaders' communications as clear, useful, and frequent. To promote transparency, the Director stated that leaders host an employee town hall every other month and distribute a weekly bulletin to share information. Executive leaders also said they walk through service areas to engage employees and collect feedback.

The Director noted that while daily meetings occurred among frontline employees and executive leaders, service chiefs previously lacked a daily meeting to discuss concerns. In late FY 2024, the Assistant Director and Deputy Associate Director for Patient Care Services began holding meetings for service chiefs. During these meetings, service chiefs raise issues identified by frontline employees and collaboratively address them. Leaders believe this system has strengthened communication.

Veteran Experiences

Patient advocates who responded to an OIG questionnaire indicated the call center was a recurring source of veteran frustration. The Associate Director explained that about five years prior to the September 2025 inspection, employees at the centralized Veterans Integrated Service

¹⁹ High Reliability Organizations focus on minimizing errors “despite highly hazardous and unpredictable conditions,” such as those found in healthcare delivery settings. Stephanie Veazie, Kim Peterson, and Donald Bourne, “Evidence Brief: Implementation of High Reliability Organization Principles,” *Evidence Synthesis Program*, May 2019.

Network (VISN) call center started to manage appointment schedules.²⁰ This change reduced veterans' ability to directly connect with facility employees and caused communication barriers and veteran dissatisfaction. Although employees developed products to help educate veterans on using the phone system, the Associate Director said the issue persists, and leaders are still working to improve veterans' phone experiences.

An advocate also noted that veterans frequently complained about the billing process for community care services. The advocate explained that a facility employee in community care now works with patient advocates to answer veterans' billing questions and resolve issues, which builds trust.

Leaders explained they also improve trust by hosting quarterly virtual veteran town halls with question-and-answer sessions. Veterans can request additional information, which leaders assign to the appropriate employee for resolution. The Associate Director for Patient Care Services and deputy associate director also visit clinical areas weekly to connect with veterans and address their concerns. The Director credited high VSignals trust scores, as shown in figure 3, to employees' dedication and compassion, and noted that veterans often describe them as passionate, innovative, and caring.

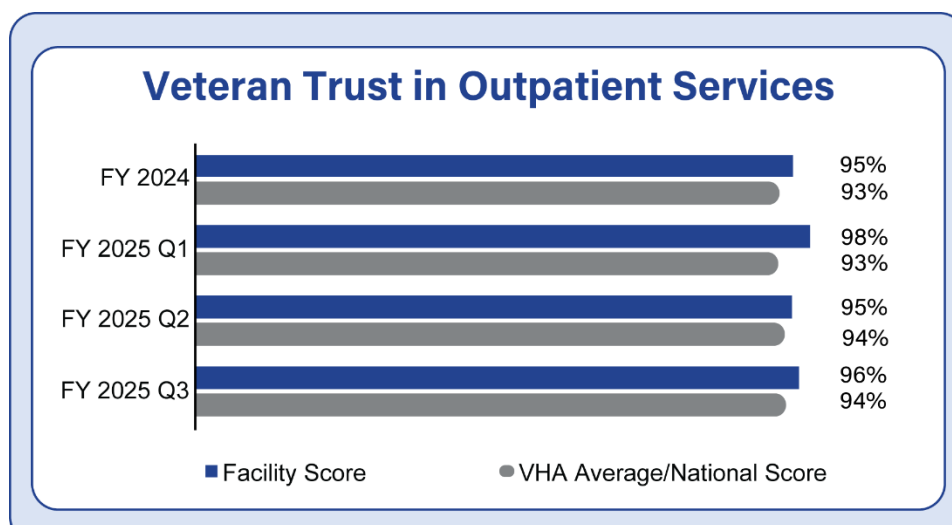


Figure 3. Veteran trust in outpatient services.
Source: VSignals data.

²⁰ VISNs are “regional systems of care working together to better meet local health care needs and provides greater access to care.” “Veterans Integrated Service Networks,” VA, accessed February 13, 2025, <https://www.va.gov/HEALTH/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>.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.²¹ 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.²²

General Inspection

The OIG team observed signs that directed veterans to the main entrance and parking areas. Parking lots and two garages provided adequate spaces, including for those with disabilities. The garages were well lit and had security cameras and police emergency call buttons installed on each level.

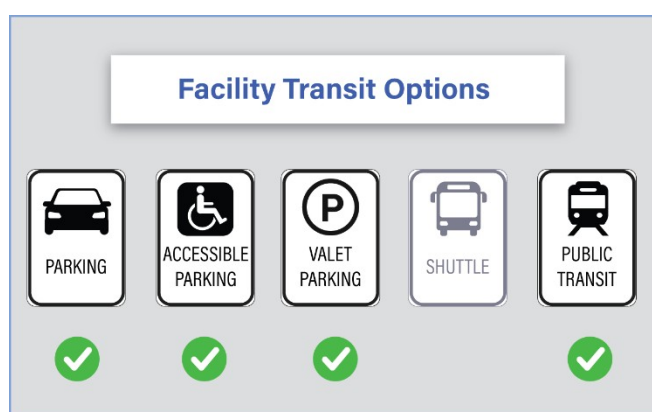


Figure 4. Transit options for arriving at the facility.
Source: OIG observations and the facility liaison's questionnaire response.

²¹ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²² 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.

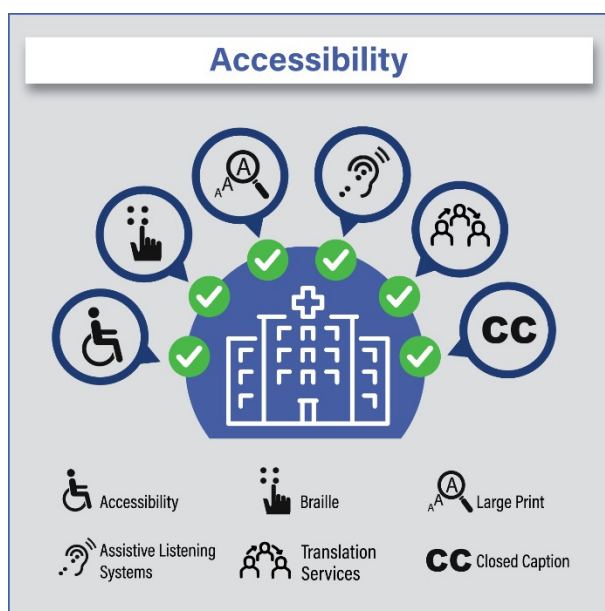


Figure 5. Accessibility tools available to veterans with impairments.

Source: OIG observations, interpretation services document, and campus map indicating parking spots.

The main entrance had an information desk with volunteers and staff to assist veterans with questions and navigation. Inspectors easily located clinical and nonclinical areas using directional signs and posted directories. Maps were available at the information desk.

The inspection team noted signs with braille characters on walls and at elevators throughout the facility. Elevators also provided audible cues to alert those with visual impairments to different floors.

The OIG team physically inspected the emergency department, intensive care unit (eighth floor), medical-surgical unit, Primary Care–Bluffs clinic, and the community living center–Valor Transitional Care. Inspectors did not find any privacy concerns.



PATIENT SAFETY

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

Communication of Urgent but Noncritical Test Results

Clinical leaders were aware of the updated VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, and were able to describe facility processes that aligned with the directive.²³ However, the facility’s policy on test result communication did not contain a procedure for communication of abnormal results that may be life-changing (such as a new cancer diagnosis) to patients at high-risk for suicide or an escalation process for communicating results when providers who ordered the tests were unavailable, as required by the directive.

Additionally, the clinical leaders said the facility lacked written workflows for each service that describe staff roles in the process for communicating test results, which is also required by VHA Directive 1088(1). When leaders do not ensure their facility policy complies with VHA

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

requirements or establish workflows for communicating test results, staff may be unaware of their responsibilities and not provide care based on the most current guidelines. In April 2026, the inspection team requested an update on leaders' actions regarding the findings. The organizational improvement and quality chief provided the team with an updated facility policy and standard operating procedure that still did not align with the directive. The team also requested service-level workflows, but the facility did not provide any, and none were incorporated in the policy.

Recommendation 1

The Director takes appropriate action so staff update the facility's test result communication policy to align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

Target date for completion: November 30, 2026

Director Comments

The facility maintains Medical Center Policy (MCP) 011-05, *Communication of Diagnostic Test Results to Providers and Patients*. To ensure alignment with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, amended September 20, 2024, the Quality Department and Chief of Staff (COS) conducted a gap analysis of MCP 011-05 against the directive's requirements. This analysis incorporated the sample service-level workflow template provided in the directive's linked FAQ (May 2026) to confirm alignment of the MCP.

Based on the gap analysis, MCP 011-05 was revised to reflect the mental health considerations for test result communication required by the directive and the Department of Veterans Affairs memo "Required Edits to Medical Center Policy and Service-level Workflows for Communicating Test Results (VIEWS 14932634)" dated July 27, 2026. The revised policy was published to the facility's "Madison Facility Publications" SharePoint site on August 3, 2026.

The facility also reviewed related governing documents to confirm consistency with Directive 1088(1). QM 7-607, *Critical Value Reporting*, version 16.0 (approved April 7, 2026), meets the directive's requirements for critical pathology and lab result communication, and SOP 114-02, *Radiology Services* (published May 29, 2026), addresses communication of critical radiology results.

The facility considers this recommendation implemented and requests closure.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Recommendation 2

The Chief of Staff and Associate Director for Patient Care Services develop workflows that describe staff members' roles in the process of communicating test results to providers and patients, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

Target date for completion: November 6, 2026

Director Comments

The Chief of Staff, in collaboration with the Associate Director for Patient Care Services, issued an action item directing services that receive and communicate test results to develop individual service-level workflows using a standardized template. These workflows will define and ensure full alignment with all required standards for staff members' roles in communicating test results to providers and patients, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.

Upon completion, the Chief of Staff and the Quality Management Department will audit each service's workflow for compliance prior to approval. Approved workflows will be published to the facility's "Communicating Test Results – Service-Level Workflows" SharePoint site ensuring compliance with current VHA requirements.

The facility anticipates completion of this action by November 6, 2026.

Providers receive test results, in addition to other communications, through view alerts (notifications in the electronic health record system). To prevent providers from receiving too many unnecessary view alerts, the deputy chief of primary care reported that clinical leaders turned off those that are nonmandatory. Leaders also said they identify providers with more than 100 unaddressed alerts and provide them with an opportunity to improve. However, if the issue continues, leaders take progressive disciplinary actions. At the time of the inspection in September 2025, the primary care chief said they had placed one provider on a focused review

(used to assess a provider’s performance during a period of time) and proposed an adverse personnel action for another who repeatedly did not address alerts in a timely manner.²⁴

VHA Directive 1088(1) also requires providers or their designee to notify patients of test results that require action within seven calendar days from when the results become available. Clinical leaders reported they rely on quarterly External Peer Review Program data, patient complaints, and providers’ performance reviews to monitor compliance.²⁵ The deputy chief of primary care described implementing a system in one community-based outpatient clinic to automatically generate test result letters for patients through electronic health records. The deputy chief said the system saves staff about one hour of work each day, but there were no plans to expand its use throughout the facility because leaders were uncertain about the renewal of the system’s contract.

Action Plans and Process Improvements

The facility had no open recommendations from the last OIG comprehensive healthcare inspection, conducted in 2023, or from the Joint Commission report published in January 2024.²⁶ To prevent repeat findings from oversight and accreditation reports, quality management staff said they track the issues as part of their continuous readiness process through the Facility Quality Council and compare them across reports to identify vulnerabilities.



INTEGRATED VETERAN CARE

VHA’s Office of Integrated Veteran Care manages veterans’ access to health care in both VA and community facilities.²⁷ 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.

²⁴ VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

²⁵ VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure “corrective action is taken when non-compliance is identified.” VHA Directive 1088(1).

²⁶ VA OIG, [*Comprehensive Healthcare Inspection of the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin*](#), Report No. 22-03167-110, March 25, 2024; The Joint Commission, *Final Accreditation Report, William S. Middleton Memorial Veterans Hospital*, January 29, 2024.

²⁷ “Community Care,” VA, accessed June 29, 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.

Primary Care Staffing and Access to Care

The facility provides care through 72 primary care teams.²⁸ The OIG team reviewed documents and found the facility met the recommendation in VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, to have at least three full-time support staff for every full-time equivalent primary care provider.²⁹ The deputy chief of primary care reported the facility had vacancies for six primary care providers (nurse practitioners), seven registered nurses, and two licensed practical nurses as of September 2025. Leaders had hired one nurse practitioner for the Baraboo clinic, who had not yet started, and staff were in the process of checking references for a nurse practitioner candidate at the Rockford clinic. Primary care leaders said VA salaries are lower than in the community, which made it difficult to recruit providers.

Some primary care panels (patients assigned to a primary care team) were below the expected baseline capacity of 1,200 patients, per VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.³⁰ The team found that from January 2024 through June 2025, panels averaged 90 percent of VHA's expected size. From FY 2024 through the third quarter of FY 2025, the facility's new patient appointment wait times averaged 20 days, which under the Code of Federal Regulations (title 38, section 17.4040) meant patients did not meet wait-time criteria for being referred to community providers (more than 20 days).³¹

Community Care Staffing and Access to Care

Although facility data showed four vacant medical support staff positions, a community care leader reported that three applicants were selected for hire within the month prior to the OIG's inspection in September 2025. Community care leaders explained that in FY 2024, referrals increased 13 percent from the previous year, partly because some services were unavailable at the facility. For example, after the loss of a vascular technician more than a year earlier, veterans who needed vascular testing were referred to the community. To manage the referral increase, leaders reported they requested additional program staff for FY 2026.

In the third quarter of FY 2025, community care staff averaged 14 days to schedule an appointment after they received a veteran's referral. VHA's *Consult Timeliness Standard Operating Procedure* expects community care staff to schedule appointments for veterans within

²⁸ Primary care teams are at the hospital and two outpatient clinics in Madison, as well as clinics in Baraboo, Beaver Dam, and Janesville, Wisconsin, and Freeport and Rockford, Illinois.

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

³⁰ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

³¹ 38 C.F.R. § 17.4040 (2025).

7 days.³² Staff reported that the largest community group practice of providers in the area (at University of Wisconsin) also receives referrals from other healthcare facilities, which limits its providers' availability and delays appointments. During the same period, patients waited an average of 43 days for their first appointment. Staff said they follow up with the community providers for updates but are unable to speed up the process.

Leaders explained they assigned a nurse practitioner to the community care program, who responds to requests for additional service authorizations from community providers. Leaders said this approach helps reduce delays in veteran care.



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.³³

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of homeless veterans who received an HCHV program intake assessment.³⁴ However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional

³² VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," last updated October 2, 2025.

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

³⁴ VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

residences for veterans with mental health or substance use conditions).³⁵ 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).”³⁶

Performance and Improvement Highlights

- The OIG team found the facility met the intake assessment (HCHV5) target in FY 2024 and in the first two quarters of FY 2025. Facility program staff said they conduct outreach at various locations, such as shelters, community resource centers, and meal sites.
- The program manager said the facility is exempt from the measures for discharges to permanent housing (HCHV1) and negative exits (HCHV2) because they do not have contracted residential services. Program staff refer veterans who need emergency housing to community homeless shelters or local hotels paid for by Supportive Services for Veteran Families (which uses private or nonprofit grants to support very low-income families who are in or transitioning to permanent housing).³⁷

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.”³⁸ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³⁹

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

³⁵ 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 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

³⁶ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

³⁷ VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

³⁹ 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).⁴⁰

Performance and Improvement Highlights

- The facility exceeded the voucher use (HMLS3) target for FY 2024 and the first two quarters of FY 2025.⁴¹ The facility program coordinator said efforts to strengthen relationships with existing and new landlords who are willing to accept vouchers has helped increase available housing. The coordinator also noted that funding from community agencies allowed veterans to offer double the required security deposits, which encouraged more landlords to accept vouchers.
- Staff partnered with property developers in Dane County who build or renovate housing for low- to moderate-income families. They contacted developers before property openings to explain the program and the benefits of partnering to house veterans, such as ongoing support from VA’s case managers. Since the program launched in 2020, program staff have secured units for veterans in about 30 new developments.
- The facility program met the employment (VASH3) target from FY 2024 through the first two quarters of FY 2025. The program coordinator attributed this success to partnerships with VA’s Compensated Work Therapy Program and local job centers in each county.⁴²

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.⁴³ Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care,

⁴⁰ 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*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁴¹ At the time of the inspection in September 2025, FY 2025 data was only available for quarters one and two.

⁴² 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 October 13, 2021, <https://www.va.gov/cwt>.

⁴³ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).⁴⁴

Performance and Improvement Highlights

- The OIG team found that facility program staff did not meet the enrollment (VJP1) target from FYs 2024 through the first two quarters of FY 2025. Staff said the measure only includes the encounters that staff enter into the national database and does not reflect all services they provide to veterans. They also noted that jail staff may not notify them about veterans who are in custody for less than 24 hours, which results in missed opportunities to enroll them in the program. The coordinator said they are working with jail staff to improve communication in these cases.
- Program staff educate community partners about deflection strategies (when first responders arrange for supportive health services as an alternative to arrest) and the services that are available through VA. In December 2024, staff hosted an event for 17 local law enforcement departments on the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act (which provides for emergency suicide care for eligible veterans in an acute crisis); VA care eligibility; and available mental health and addiction services.⁴⁵ During the event, VA police and facility program staff trained attendees to safely engage veterans in the community who are experiencing a crisis and connect them with services.

⁴⁴ 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*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁴⁵ Veterans COMPACT Act of 2020, Pub. L. No. 116-214, 134 Stat. 1026 (2020).

Conclusion

To assist leaders in evaluating the quality of care at the William S. Middleton Memorial Veterans Hospital and Clinics, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the communication of test results and service-level workflows. 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.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.⁴⁶ 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 September 22 through 25, 2025, and requested an update in April and September 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.⁴⁷ 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*.⁴⁸

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁴⁹ 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.

⁴⁶ 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.

⁴⁷ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁴⁸ 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.

⁴⁹ 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>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁵⁰ 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.

⁵⁰ 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: September 10, 2026

From: Network Director, VA MidAmerica Health Network (10N3)

Subj: Healthcare Facility Inspection of the William S. Middleton Memorial Veterans Hospital and Clinics in Madison, Wisconsin

To: Director, Office of Healthcare Inspections (54HF05)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and provide a response to the draft report, Healthcare Facility Inspection of the William S. Middleton Memorial Veterans Hospital and Clinics in Madison, Wisconsin.
2. I concur with the findings and recommendations identified by OIG, and the corrective action plans submitted by the facility.
3. I would like to thank the OIG inspection team for their review of the William S. Middleton Memorial Veterans Hospital and Clinics.

(Original signed by:)

Daniel S. Zomchek, Ph.D.

Veterans Integrated Service Network 3 Director, Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 3, 2026

From: Director, William S. Middleton Memorial Veterans Hospital and Clinics (607)

Subj: Healthcare Facility Inspection of the William S. Middleton Memorial Veterans Hospital and Clinics in Madison, Wisconsin

To: Director, VA MidAmerica Health Network (10N3)

Director, Health Service Area 3.3

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Healthcare Facility Inspection of the William S. Middleton Memorial Veterans Hospital and Clinics.
2. A corrective action plan has been implemented as detailed in the attached report.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Christine Kleckner
Medical Center Executive Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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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.