US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Philadelphia Healthcare System in Pennsylvania

Healthcare Facility Inspection	**25-00255-206**	**September 4, 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 VA Philadelphia Healthcare System (the facility) from September 15 through 18, 2025. The facility is rated as *high complexity* and in fiscal year 2025, provided care to approximately 71,000 veterans.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **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 The facility's surveillance system had many nonoperational cameras, and the equipment was outdated. The Veterans Integrated Service Network (VISN) plans to work with the facility to upgrade the surveillance system.[3] The OIG team also found that a liquid nitrogen storage tank was not stored according to the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code, NFPA 55*, which requires portable tanks to be secured and stored in a locked room that meets standards.[4] The OIG made two recommendations for corrective action.

[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." "Trip Pack - Operational Statistics Table FY2026 Through March," VHA Support Service Center, accessed April 13, 2026, https://reports.vssc.med.va.gov//ReportViewer. (This web page is not publicly accessible.)

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

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

[4] National Fire Protection Association, *Compressed Gases and Cryogenic Fluids Code*, NFPA 55, 2023 edition, https://www.nfpa.org/codes-and-standards/nfpa-55.

- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[5] 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 been recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Veterans Integrated Service Network Director and facility Director take appropriate action for the surveillance system to be fully operational.
2. The Director takes appropriate actions to secure portable liquid nitrogen tanks and store the tanks according to the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code*, *NFPA 55* requirements.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the findings and recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
for Healthcare Inspections

[5] 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.

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 (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]

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[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 VA Philadelphia Healthcare System (the facility) serves veterans across six counties in southeastern Pennsylvania and southern New Jersey. It includes a medical center in Philadelphia and community-based outpatient clinics in Horsham and West Philadelphia, Pennsylvania, as well as Burlington, Gloucester, and Camden Counties in New Jersey. In fiscal year (FY) 2025, the medical care budget was approximately $1 billion; the facility had 141 hospital, 40 domiciliary, and 174 community living center beds and served approximately 71,000 veterans.[11]

Figure 1. *Facility photo.*
Source: "VA Philadelphia Health Care," VA, accessed March 17, 2026, https://www.va.gov/philadelphia-health-care.

The OIG team inspected the facility from September 15 through 18, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), Deputy Director, Assistant Director, Chief of Staff, Associate Director for Patient Care Services, and Director of Quality Management. The facility provided documents showing the team had worked together since March 2025.

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 team administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which provide information about veterans' experiences after an appointment and their level of

[11] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/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. "Trip Pack - Operational Statistics Table FY2026 Through March," VHA Support Service Center, accessed April 13, 2026, https://reports.vssc.med.va.gov/ReportViewer. (This web page is not publicly accessible.)

[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.

trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from a patient advocate.[14]

System Shocks

During a September 2025 interview, executive leaders identified several system shocks. The shocks involved boiler malfunctions caused by aging infrastructure and delays in the contracting process for making repairs, as well as three facility floods over two years due to water pipe breaks. Leaders explained the facility relies on four high-pressure boilers to provide steam for heating and sterilizing medical equipment. Due to the age of the boilers, they malfunction frequently and the facility often operates with only one functioning boiler. In response, the facility received approval for a contractor to install a contingency boiler, which would access publicly generated steam (produced by a public utility) if all the facility boilers fail.

Leaders also said upper-floor water pipe breaks caused three major floods in August 2022 and May and December 2023. These incidents caused water to cascade through the lower levels down to the basement. The mental health clinic was among the most affected areas, and a small number of inpatient units also had damage. Additionally, a hybrid operating room (an operating room with a built-in x-ray machine), which opened in October 2023, sustained significant equipment damage during the December 2023 flood. Repairs were still ongoing at the time of the inspection in fall 2025. The OIG requested an update, and the facility confirmed the hybrid operating room reopened in February 2026.

Despite the flooding, leaders said staff did not have to cancel any outpatient appointments. Staff set up alternative treatment areas and converted some appointments to telehealth (virtual care). They also relocated the affected inpatient units to other areas in the facility. However, staff rescheduled some surgical patients or referred them to community providers.

Employee Experiences

As shown in figure 2, most respondents to the OIG questionnaire identified the VA mission, pay and benefits, and job satisfaction as the top reasons they continue to work at the facility. When asked what makes them consider leaving, approximately 40 percent said they had no plans to leave, while others provided a range of reasons—with 28 percent citing stress and burnout.

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

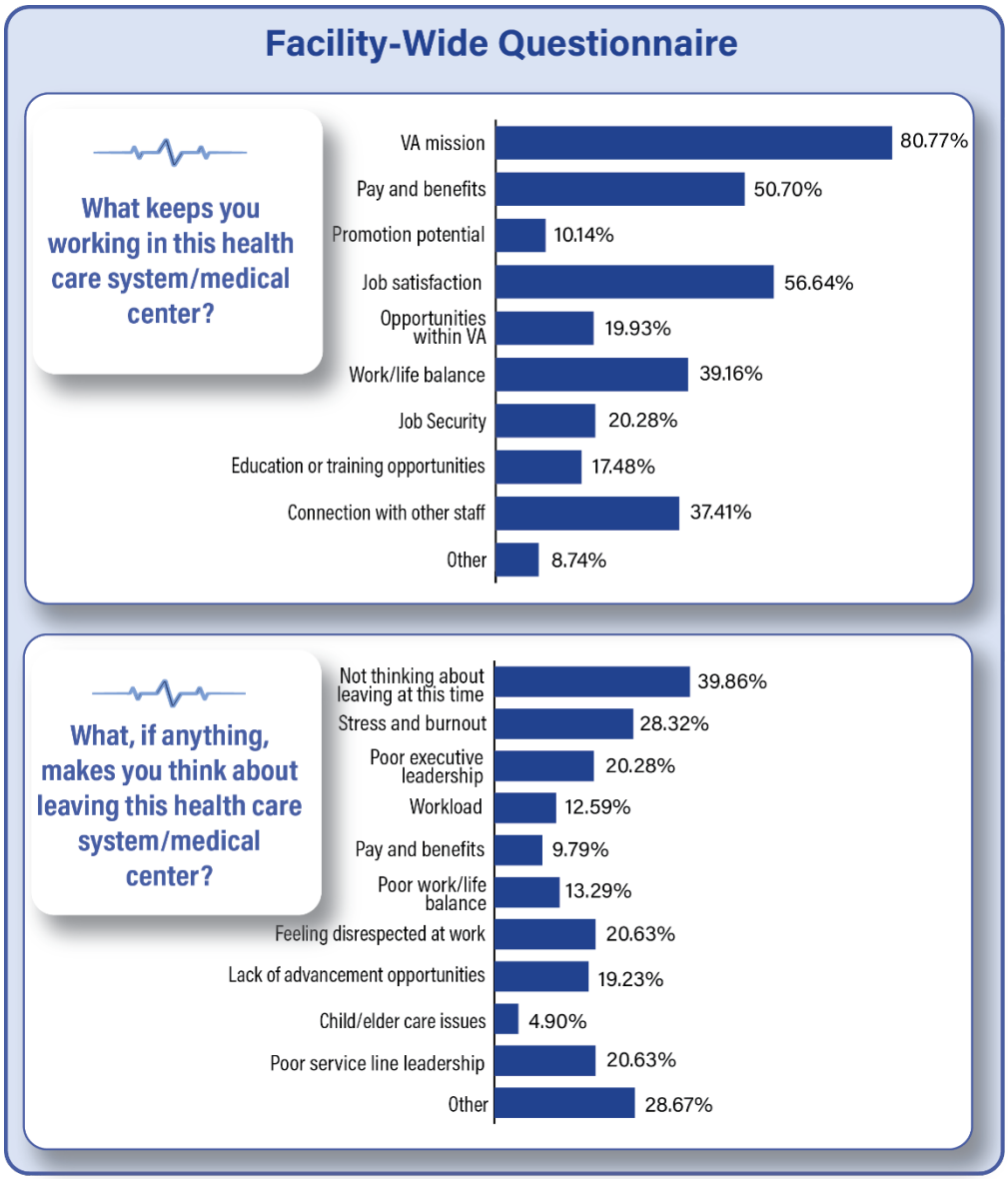

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Executive leaders described communicating with employees through multiple methods, including town halls, service manager meetings, unit and service area visits, and weekly emails to highlight key messages and events for the upcoming week. The Director routinely visited various units and service areas throughout the facility and community-based outpatient clinics, with some visits occurring on weekends and holidays.

Leaders reported encouraging employees to raise topics and ask questions during meetings and town hall sessions. The Director emphasized that leaders intentionally seek employees' input to solve problems and identify areas for improvement.

Respondents to the OIG questionnaire largely agreed or strongly agreed that executive leaders have improved communication practices, and communication is clear, frequent, and useful. Additionally, 80 percent of respondents said they feel safe reporting patient or staff safety concerns, and 64 percent said they feel comfortable suggesting actions to improve their work environment. These responses indicate that leaders' efforts to foster a responsive and supportive workplace were successful.

Veteran Experiences

The facility's outpatient VSignals trust scores consistently exceeded VHA averages, indicating that veterans trust the facility and have confidence in the care they receive. Leaders reported regularly reviewing VSignals scores and noted most feedback was complimentary.

In an OIG questionnaire, a patient advocate identified the three most common veteran complaints as delays in provider communications and appointment scheduling, as well as veterans' concerns about being shown respect and treated with dignity. Leaders confirmed they were aware of these concerns and met with the Veterans Experience Committee weekly to address communications and scheduling complaints and to improve services. Leaders also implemented two initiatives: *Get Well* is an interactive information system for inpatients to gain more information and *Commit to Sit* encourages facility staff to sit with veterans and family members to improve communications. Both were designed to increase personal engagement between staff and veterans in their care.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[15] 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.[16]

General Inspection

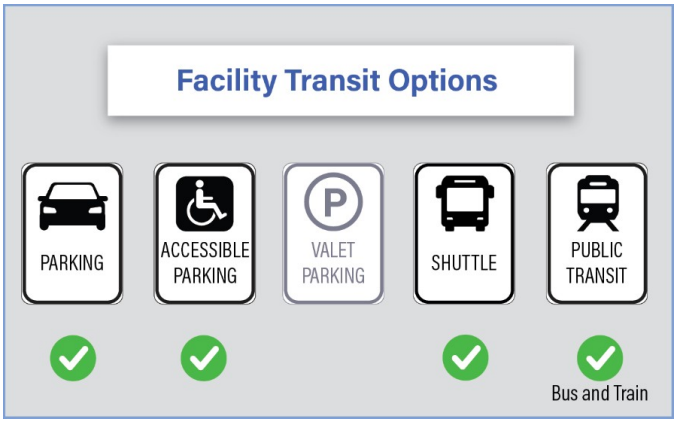

Figure 3. *Transit options for arriving at the facility. Source: OIG questionnaire responses, a parking map and inventory list, and team observations.*

The facility had signs that directed drivers into a parking garage with ample spaces, including accessible spaces for individuals with mobility challenges, as well as emergency telephones in the stairwells. However, many overhead lights in the garage were not working. Additionally, some fixtures were missing covers, and one had exposed wiring. Due to the lack of lighting, the garage was dim. A facility leader explained that water had damaged the garage's electrical system and they were installing temporary lighting. Leaders were also working to upgrade the electrical system in the garage and improve the lighting. Because of these ongoing efforts, the OIG did not make a recommendation in this report.

The OIG team also observed security cameras in the facility's parking garage. During a visit to the Security Control Center, the team found (and the chief of police confirmed) that many cameras were not operational, and those that were functioning displayed grainy, low-quality images. The chief of police explained that the system was outdated, and replacement parts were difficult to obtain. The facility is in a large metropolitan area with a constant flow of patients,

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

[16] 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.

staff, and visitors. Inadequate surveillance impairs the facility's ability to maintain a safe environment, even though environment of care leaders said VA police patrol throughout the facility grounds to ensure the areas are secure.

The Code of Federal Regulations (title 42, section 482.41) requires staff to ensure the overall hospital environment maintains "the safety and well-being of patients."[17] Additionally, the *VA Emergency Preparedness Act* states the "Secretary shall take appropriate actions to provide for the security of Department medical centers and research facilities, including staff and patients."[18] The chief of police reported that Veterans Integrated Service Network (VISN) leaders planned to upgrade the surveillance system.[19] Facility leaders explained that the police station also needed to be renovated and they are hoping the two projects occur at the same time.

Recommendation 1

The Veterans Integrated Service Network Director and facility Director take appropriate action for the surveillance system to be fully operational.

_X_ Concur

____ Nonconcur

Target date for completion: March 2029

Director Comments

Due to the outdated camera surveillance system, VISN 4 is upgrading and standardizing CCTV systems across all identified facilities. The Philadelphia VA Medical Center will issue a solicitation to replace all cameras at the medical center and its CBOCs. Contract award is expected by September 30, 2027, with installation to be completed within 18 months of award.

The main entrance features a covered passenger loading zone. A wide automatic door opens into a well-lit lobby with an information desk, a large seating area, and available wheelchairs. The lobby also has a vendor across from the information desk who sells coffee and snacks.

[17] 42 C.F.R. § 482.41 (2024).

[18] Department of Veterans Affairs Emergency Preparedness Act of 2002, Pub. L. No. 107-287, 116 Stat. 2024.

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

The facility offers multiple navigational methods to help veterans find their way around, including directional signs, handheld maps, and readily available greeters and volunteers to provide directions or escort veterans to their desired destinations. For visually impaired veterans, door signs and elevator panels include braille markings. Additionally, the facility liaison provided information that the advanced low vision clinic offers assistive equipment such as reading devices and magnifiers. Staff provide tools and resources to hearing-impaired veterans, such as personal amplifiers.

The facility was clean and well-maintained, and employees protected patients' privacy. The OIG team found corrugated boxes in a clean supply room, which can be an infection risk, but staff removed them immediately.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: Facility policy, OIG questionnaire response, team observations, and a parking inventory list.

The OIG team also found an unsecured liquid nitrogen storage tank (not attached to the wall) in a locked room that did not have enhanced ventilation and monitoring which would alert and protect staff from a gas leak. The National Fire Protection Association's *Health Care Facilities Code*, *NFPA 99*, outlines the following as some of the hazards associated with a liquid nitrogen leak: "1. Hazards due to exposure to very low temperatures (e.g., frost burns, frostbite), 2. Hazards due to rapid vaporization (i.e., expansion of volume) of the liquid into gas (e.g., explosion),…4. Hazards due to vaporization of the liquid and the management of the resulting gas (e.g., liquid nitrogen discharge into room air with the consequence of depleting the room oxygen)."[20] The National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code, NFPA 55*, calls for compressed gas cylinders, containers, and tanks in use or in storage to

[20] National Fire Protection Association, *Health Care Facilities Code*, NFPA 99, 2024 edition, https://www.nfpa.org/codes-and-standards/nfpa-99; The Public Buildings Amendments of 1988, Pub. L. No. 100-678, 102 Stat. 4049, "requires all federal agencies to follow the latest editions of nationally recognized fire and life safety codes….VA has adopted the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), which establish a minimum acceptable level of life safety and property protection. Life safety requirements are specifically addressed in NFPA 101." VA Manual, *Fire Protection Design Manual Ninth Edition*, November 1, 2023.

"be secured to prevent them from falling or being knocked over by corralling them and securing them to a cart, framework, or fixed object by use of a restraint, unless otherwise permitted."[21]

Recommendation 2

The Director takes appropriate actions to secure portable liquid nitrogen tanks and store the tanks according to the National Fire Protection Association's *Compressed Gases and Cryogenic Fluids Code, NFPA 55* requirements.

_X_ Concur

____ Nonconcur

Target date for completion: February 2027

Director Comments

The facility is evaluating alternative storage locations, transfer processes, and vendors to eliminate the need for large on-site liquid nitrogen tanks in the Dermatology suite. As interim risk-reduction measures, the facility will secure the tank to the wall, install a punch-code door lock, oxygen alarms in the storage room, and implement updated Life Safety competencies for staff responsible for filling liquid nitrogen cryospray devices. Interim corrective actions will be completed by August 31, 2026. Implementation of a permanent corrective action plan is targeted for February 2027.

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

Communication of Urgent but Noncritical Test Results

The facility has policies and processes to communicate abnormal test results to providers, identify a surrogate when a provider is unavailable or has left the facility, and alert the provider about test results from community providers. In a September 2025 interview, facility leaders and

[21] National Fire Protection Association, *Compressed Gases and Cryogenic Fluids Code*, NFPA 55, 2023 edition, https://www.nfpa.org/codes-and-standards/nfpa-55; The Public Buildings Amendments of 1988, Pub. L. No. 100-678, 102 Stat. 4049, "requires all federal agencies to follow the latest editions of nationally recognized fire and life safety codes.…VA has adopted the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), which establish a minimum acceptable level of life safety and property protection. Life safety requirements are specifically addressed in NFPA 101." VA Manual, *Fire Protection Design Manual Ninth Edition*, November 1, 2023.

quality management staff explained that when a provider is unavailable to receive test results, staff use an electronic application for provider on-call schedules that included contact information for each person on the list responsible for responding. Staff could access the application through the facility website and the electronic health record system.

In accordance with Medical Center Policy 113-02, *Communication of Test Results to Providers and Patients*, facility leaders reported to the OIG team that laboratory staff communicated critical results to providers within 15 minutes from October 2024 through August 2025 100 percent of the time.[22] Through the External Peer Review Program, the Chief of Staff and quality management staff monitor documents to ensure providers communicate test results to patients within seven days of test result availability, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[23] In the second quarter of FY 2025, program data showed providers communicated abnormal test results to patients within seven days 66 percent of the time. Facility leaders and quality management staff reported that the lower percentage was because some specialty care providers did not communicate abnormal results within seven days, as required. In response, service chiefs educated providers on the requirement to communicate test results to patients when available, which improved compliance to 90 percent in the third quarter of FY 2025. The OIG team reviewed data from the fourth quarter of FY 2025 through the second quarter of FY 2026 and found sustained compliance.

Leaders explained that when community providers give facility staff access to their electronic health records, it helps staff retrieve test results for patients referred to a community provider. If concerns arise, staff report them during Community Care Oversight Council meetings, where staff track them to resolution.

The Chief of Staff identified a barrier to communicating test results to patients experiencing homelessness because of limited contact information. In these cases, providers try to schedule follow-up appointments before the patient leaves the facility or seek help from social workers. The chief also said the facility distributes donated electronic devices, such as tablets, to vulnerable patients, and staff train them to use My HealtheVet (the VHA online health portal) to communicate with their care teams.

[22] Corporal Michael J. Crescenz VA Medical Center, MCP [medical center policy] 113-02, *Communication of Test Results to Providers and Patients*, January 22, 2025.

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

Action Plans and Process Improvements

The facility had no open (unimplemented) recommendations related to test result communication from a previous OIG report published in September 2023.[24] Leaders explained that quality management staff meet with various services to develop and track action plans through completion, monitor sustainment, and report this information to the Quality Executive Board; VISN leaders also track action items. The OIG reviewed selected meeting minutes for FY 2025 and found attendees consistently addressed findings, recommendations, and the status of action plans.

During the September 2025 interview with OIG inspectors, quality management staff reported that executive leaders support process improvement projects and that no barriers exist to initiating them. Leaders and quality management staff described ways they identify improvement opportunities, including through the Joint Patient Safety Reporting system (a database for employees to document patient safety events), peer reviews (review of care to identify learning opportunities), safety huddles (short meetings) and forums, and executive leaders' visits to work areas.[25] To share patient safety lessons learned, the Chief of Staff and quality management staff said they use communication tools such as facility newsletters.

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

The facility has 41 primary care teams at the medical center and 26 teams across the community-based outpatient clinics. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT)*

[24] VA OIG, *Comprehensive Healthcare Inspection of the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, Pennsylvania*, Report No. 22-00071-216, September 26, 2023.

[25] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 6.0*, October 2025; VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024; "Patient Safety Huddle Board," VHA National Center for Patient Safety, last updated April 3, 2018, https://www.patientsafety.va.gov//Patient_Safety_Huddle_Board.

[26] "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.

Handbook recommends that each full-time provider has a registered nurse, a licensed practical nurse, and a medical support assistant (a ratio of 1 provider to 3 support staff). Clinical pharmacy specialists, social workers, and dietitians support multiple primary care teams.[27] The OIG found at the time of the inspection in September 2025, the facility did not meet VHA guidance for core primary care staffing levels. Facility leaders reported this was due to vacancies for 7 registered nurses, 9 licensed practical nurses, and 12 medical support assistants. Employees and leaders reported that registered and licensed practical nurses and medical support assistants cover multiple care teams, which may lead to burnout.

Although nursing leaders offered position incentives, recruitment remained low. A high pharmacist turnover rate created an additional primary care staffing deficit. The lack of pharmacists led to a decrease in clinic pharmacy appointments to manage chronic illnesses, such as hypertension (high blood pressure). In response to staffing challenges, facility leaders limited the number of patients assigned to providers. Leaders also dedicated a block of time for primary care teams to review clinic schedules and patients' test results and offered flexible work schedules to some staff to improve any space constraints due to the return to in-person work requirement.[28]

Community Care Staffing and Access to Care

Community care leaders within the facility reported five administrative and seven clinical vacancies, which created challenges with appointment scheduling and timely follow-up, as well as obtaining medical records from community providers. At the time of the inspection in September 2025, leaders approved three administrative and two clinical positions for recruitment.

In June 2025, the average time to schedule a community care appointment was eight days, which exceeded the seven days required by VHA's *Consult Timeliness Standard Operating Procedure*.[29] To address delays, the chief of community care said the third-party administrator (an external company that manages the contracts with community providers) identified providers who were readily available and willing to schedule appointments. Employees said leaders modified scheduling processes so medical support assistants could make appointments based on the number of days patients have been waiting. After this change, employees noted an improvement. To monitor timeliness, community care leaders said they implemented a dashboard to track each patient's care coordination status, communicate with providers, and obtain medical records. Leaders said that access to community providers' electronic medical

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

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

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

records also improved their ability to retrieve medical documents; however, employees reported that not all community providers granted access. Leaders added that when documents were unavailable, nurses and the medical support assistants contacted provider offices directly.

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. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[30]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[31] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[32] 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

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

[31] 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 2025 Homeless Performance Measures*, November 2024.

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

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

Performance and Improvement Highlights

- The facility program came close to meeting the intake (HCHV5) target and met the permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2025. Program staff attributed the successes to proactive outreach efforts and collaboration with community homeless services.
- HCHV staff reported that the facility held its first surge event (a short-term, intensive outreach campaign to reduce homelessness) in August 2025, which resulted in housing five unsheltered veterans on the same day. Staff credited the success to collaboration with other VA staff and community partners.
- Staff reported they contracted with a community partner to offer medical respite beds to veterans experiencing or at risk of homelessness. This program provides a safe, comfortable environment where veterans can recover from surgery, injury, or illness and prepare for procedures such as a colonoscopy. The respite care reduces hospital readmissions and improves health outcomes for veterans.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH housing program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[34] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[35]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[36]

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

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

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

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

Performance and Improvement Highlights

- The facility program met the voucher use (HMLS3) target of 90 percent for FY 2025. A program leader explained the program received an additional 180 vouchers from January 2024 through August 2025 but did not receive approval to hire staff to support the increased workload. The program managed 1,348 vouchers as of the end of FY 2025, with vouchers continually assigned over time.
- The program met the employment (VASH3) target for FY 2025. A leader stated that staff received referrals from many sources, including the National Call Center for Homeless Veterans, VA providers, Community Resource and Referral Center walk-ins, concerned individuals, community partners, and veteran self-referrals.[37]

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]

Performance and Improvement Highlights

- The facility program exceeded the enrollment (VJP1) target for FY 2025. An employee attributed this success to thorough and timely documentation of veteran assessments, referrals, and program exits in the Homeless Operations, Management, and Evaluation System database (software for collecting homeless veterans' information).[40]

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[37] Veterans and their family members can contact "the National Call Center for Homeless Veterans, where trained counselors are ready to talk confidentially 24 hours a day, 7 days a week." "National Call Center for Homeless Veterans," VA, last updated May 1, 2025, https://www.va.gov/homeless/NationalCallCenter. "CRRCs [Community Resource and Referral Centers] provide Veterans who are homeless and at risk of homelessness with one-stop access to community-based, multiagency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits." "VA Homeless Programs," VA, last updated September 16, 2025, https://department.va.gov/hchv/crrc.

[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.*

[40] VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

- Program staff reported that they trained local law enforcement agencies, as well as public transportation and police at the Amtrak station, to connect veterans with support services and voluntary treatment, diverting them from arrests or involuntary commitment. Trained officers, who are veterans themselves, used crisis intervention techniques and shared military experience to deescalate situations and build rapport with veterans in crisis.

Conclusion

To assist leaders in evaluating the quality of care at the VA Philadelphia Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the surveillance system and liquid nitrogen tank storage. 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 team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from September 15 through 18, 2025. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[41] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust*.[42]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[43] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

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

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

[42] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[43] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

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

specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 21, 2026

From: Director, VISN 1 (10N1)

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

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

Chief Integrity and Compliance Officer (10OIC)

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

(Original signed by:)

Joseph Scotchlas
Interim Deputy Network Director, VISN 1

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 10, 2026

From: Director, VA Philadelphia Healthcare System (642)

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

To: Director, VISN 1 (10N1)

1. I have reviewed the draft report of the Office of Inspector General (OIG) Healthcare Facility Inspection that was conducted at the Corporal Michael J Crescenz VA Medical Center in September 2025. I concur with the OIG's recommendations outlined in the draft report.
2. I am submitting corrective action plans for the recommendations.
3. I appreciate the insights and guidance provided by the OIG as a collaborative partner in assisting our facility to improve processes as we strive to deliver high quality care for our veterans.

(Original signed by:)

Karen Flaherty-Oxler, MSN, RN
Philadelphia VA Healthcare System 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.