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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Central Virginia VA Health Care System in Richmond

**Healthcare Facility
Inspection**

25-00213-242

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 Central Virginia VA Health Care System (the facility) from April 22 through 24, 2025. Additionally, the OIG team contacted facility staff in December 2025, January 2026, and June 2026 to obtain updated information and reviewed primary care patient wait time data in May 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 92,000 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. In July 2023, VHA Directive 1088, *Communicating Test Results to Providers and Patients* required facilities to implement a local policy for test result communication within 6 to 12 months; however, leaders did not implement the policy until April 2025, and it did not include how providers should address life-changing test results for patients at high risk for suicide.³ Leaders also did not develop service-level workflows that describe each team member's role in the communication process, as required. The OIG made two recommendations.
- **Primary Care.** The OIG assessed whether primary care teams were staffed according to VHA Directive 1406(3), *Patient Centered Management Module*

¹ VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and 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] 6) Richmond VA Medical Center*, last updated January 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.

(PCMM) for Primary Care and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.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 actions so leaders update the facility's policy for communicating test results to include how providers communicate life-changing results to patients at high risk for suicide, as required by 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 how each team member participates in the process to communicate test results, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The Health Service Area 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). Based on information provided, the OIG considers recommendation 1 closed. The OIG will follow up on the planned actions for recommendation 2 until they are completed.



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⁴ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

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

Executive Summary	i
Abbreviations	iii
Introduction.....	1
Culture.....	3
Environment of Care.....	6
Patient Safety	8
Recommendation 1.....	9
Recommendation 2.....	9
Primary Care	11
Veteran-Centered Safety Net	13
Conclusion	16
Appendix A: Methodology	17
Appendix B: Health Service Area Director Comments.....	19
Appendix C: Facility Director Comments	20
OIG Contact and Staff Acknowledgments	21
Report Distribution	22



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

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



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



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



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



Primary Care: Facilities must staff primary care teams in compliance with directives and guidance governing the VHA multidisciplinary care model.⁹



Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.¹⁰

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

⁶ Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," *BMJ Open* 7, no. 11 (2017): 1–11, <https://doi.org/10.1136/bmjopen-2017-017708>.

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

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

⁹ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

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

The Central Virginia VA Health Care System (the facility) provides care to patients at the Richmond VA Medical Center, the Fredericksburg VA Health Care Center, and community-based outpatient clinics in Charlottesville, Emporia, and Henrico. The medical center serves as one of VHA's five Polytrauma Rehabilitation Centers, which care for both veterans and active-duty military members.¹¹ The medical center is also recognized as a Center of Excellence for epilepsy, headaches, and lung cancer screening.¹² The Fredericksburg site, which opened in March 2025, is the nation's largest VA health care center.



Figure 1. Richmond VA Medical Center.
Source: "VA Richmond Health Care," VA, accessed February 3, 2026, <https://www.va.gov/richmond-health-care>.

In fiscal year (FY) 2025, the facility's medical care budget was about \$1.4 billion, and staff provided care to about 92,000 veterans. The facility had 243 hospital, 98 community living center, and 16 domiciliary beds.¹³

The OIG inspected the facility from April 22 through 24, 2025; contacted facility staff in December 2025, January 2026, and June 2026 to obtain updated information; and reviewed primary care patient wait time data in May 2026. The executive leaders referred to throughout this report include the Executive Director (Director), interim Chief of Staff (permanently hired in the position November 2025), acting Associate Director, acting Assistant Director/Chief Experience Officer, Associate Director for Patient Care Services, and the Assistant Director and Administrator for the Fredericksburg VA Health Care Center. At the time of the inspection, the Associate Director was Acting Executive Director at another VA facility, and the Assistant

¹¹ "Polytrauma Rehabilitation Centers (PRCs) provide acute, comprehensive, inpatient rehabilitation" with a team of "rehabilitation professionals and consultants from other specialties related to polytrauma." "Polytrauma/TBI [traumatic brain injury] System of Care," VA, last updated June 3, 2015, <https://www.polytrauma.va.gov>.

¹² "The VA Epilepsy Centers of Excellence (ECoE) is a network of 19 sites that provide comprehensive epilepsy evaluation and care for Veterans with seizure disorders." "Epilepsy Centers of Excellence (ECoE)," VA, last updated February 5, 2024, <https://www.epilepsy.va.gov>. The Headache Centers of Excellence Program is a network of 17 sites working to "improve headache care quality, delivery, and access for Veterans living with headache disease." "Polytrauma/TBI System of Care, VHA Headache Centers of Excellence Program," VA, last updated May 13, 2022, <https://www.polytrauma.va.gov/headache>. "Central Virginia VA Health Care System (CVHCS) has been designated as Screening Center of Excellence by the GO2 Foundation for Lung Cancer for its ongoing commitment to effective lung cancer screening." VA, "Richmond VA Center of Excellence for Lung Cancer Screenings," news release, August 19, 2020, <https://news.va.gov/78152/richmond-lung-cancer-screenings>.

¹³ VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 6) Richmond VA Medical Center*, last updated January 13, 2026; A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/Geriatrics/VA_CLC. 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>.

Director/Chief Experience Officer was serving as acting Associate Director. The most tenured executive leader was the Director, who had been in the position since March 2019.



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.¹⁴ The OIG administered its own facility-wide questionnaire, interviewed executive and facility leaders and employees, and considered data from patient advocates.¹⁵

System Shocks

Executive leaders and questionnaire respondents identified a system shock that resulted from a major snowstorm on January 6, 2025. The snowstorm caused the city of Richmond's water pump to malfunction and shut down the water plant for a week. The acting Associate Director explained that employees discharged as many patients as possible and transferred those who required continued inpatient care to the VA Hampton Healthcare System in Virginia. In addition, leaders said they rescheduled noncritical surgical procedures and worked with Hampton employees who cleaned and sterilized equipment at the Hampton facility and returned it to Richmond when patients needed emergency surgery.

Further, in response to the water outage, executive leaders said they activated an incident command center, set up portable toilets and hand-washing stations, arranged for water trucks to bring clean water for the boilers (used to provide heat and hot water), and conserved resources by only heating inpatient areas. Employees also used buckets to take water from the therapy pool to flush the toilets. In addition, the winter weather caused unsafe travel conditions and some kitchen staff absences. In response, nurses, psychologists, and social workers delivered meals to inpatients. Leaders emphasized that employees' response to the situation and their willingness to help where needed reflected the facility's culture.

The acting Assistant Director discussed lessons learned and said although leaders believed they maintained good communication throughout the event, employee feedback indicated they could improve. As a result, leaders added an emergency management link to the facility's internal

¹⁴ 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>.

¹⁵ 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.

website where employees can find weekly updates on operations. The link changes from yellow to red if there is an emergency, and they plan to update it every couple of hours during an event to keep employees informed.

Employee Experiences

The OIG received 448 responses to its questionnaire, with respondents indicating they generally felt comfortable suggesting ways to improve their work environment and most agreeing the culture was moving in the right direction, as shown in figure 2. Executive leaders said they offered to train and mentor all supervisors on how to create a psychologically safe work environment and coached them on team building.¹⁶ If necessary, leaders assigned a psychologist from the Engagement and Experience Office, which focuses on employee and veteran experiences, to assist.

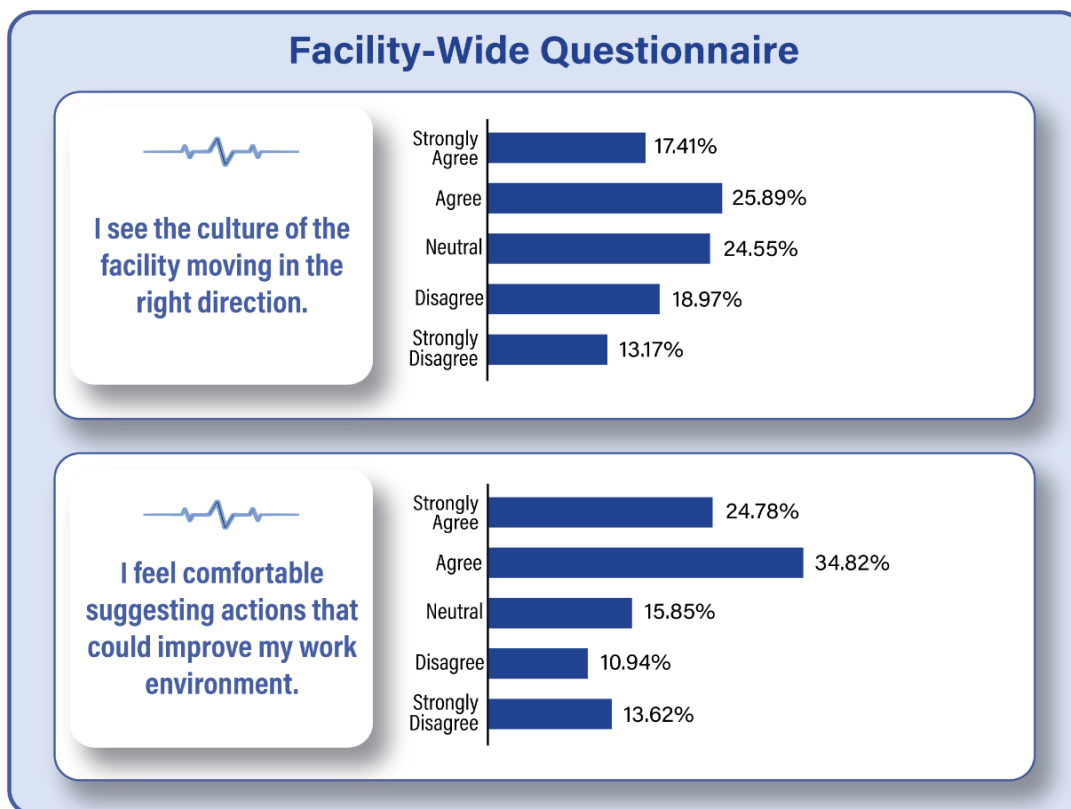


Figure 2. Employee perceptions of facility culture.
Source: OIG analysis of selected questionnaire responses.

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

Executive leaders stated they observed, and employees reported, increased stress due to the deferred resignation program.¹⁷ The Director explained that administrative employees disproportionately resigned, which created vacancies in supply chain management. Consequently, leaders shifted many of the supply chain duties onto nurses, which added to their workload.

Additionally, the acting Assistant Director said the Engagement and Experience Office implemented a Random Act of Kindness Week, which challenges employees to perform kind gestures for one another. The leader further explained that the well-being office chief created a training series to help leaders support employees; it focused on how to manage stress, communicate effectively, and identify signs of burnout.

Veteran Experiences

Executive leaders reported they obtain veterans' feedback from a variety of sources, such as veteran experience surveys and patient advocates. The acting Associate Director explained that when a concern appears on a satisfaction survey, the patient advocate contacts the veteran, and leaders review the issue to determine how to address it.

During the April 2025 inspection, executive leaders shared an example of how they addressed veterans' reports that they could not reach employees by phone. They explained that limited call center capacity, phone system issues, and employee vacancies in areas such as beneficiary travel and prosthetics contributed to the problem. To improve access, leaders increased contractor operator staffing about two years previously and later hired a communication specialist to monitor call performance and train employees. They noted that phone system changes in fall 2024 caused additional routing problems that required more troubleshooting and employee training. Although call answer rates improved, ongoing vacancies continued to affect phone access, and the communication specialist created call-routing groups to ensure calls transferred to available employees until answered.

¹⁷ The Office of Personnel Management offered federal employees the option to resign from federal service in January 2025 but 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>.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.¹⁸ The OIG team assessed how the 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.¹⁹

General Inspection

During the April 2025 inspection, the OIG team observed that the medical center and health care center offered on-site parking with accessible options, covered passenger loading zones, and access to public transportation. Valet services were available at the medical center but not at other sites visited in the inspection. There was no shuttle available to transport patients from distant parking to the facility entrance.

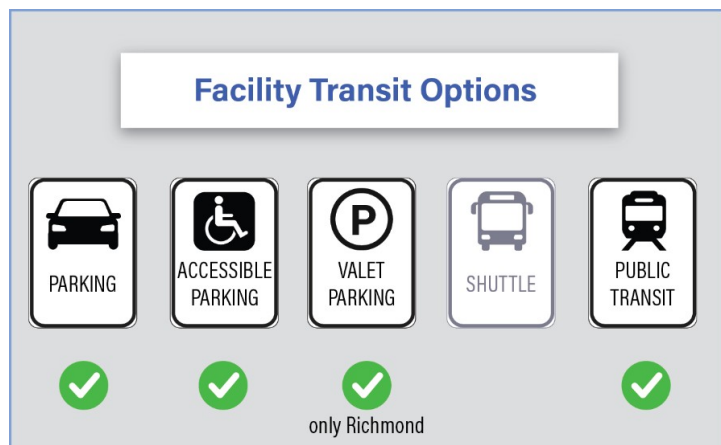


Figure 3. Transit options for arriving at the facility.

Source: OIG inspector photos and observations, map of facility parking spaces, and an interview with facility leaders.

The team located the main entrances at both locations following clear signs posted throughout the parking lots. The entrances were well lit and welcoming, with power-assisted doors, plenty of seating, and wheelchairs available for veterans with mobility needs. Volunteers staffed the information desks, each building had large-print directional signs and directories posted on walls, and the medical center had an electronic wayfinding (navigational) application. Inspectors also noted braille on elevator buttons and placards, as well as audio elevator instructions to help veterans navigate independently.

¹⁸ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

¹⁹ 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.

However, during the general inspection of patient care areas, OIG inspectors found environmental management services' supplies, such as a cleaning cart, clean curtains, and unused waste bags, stored in biohazard storage rooms in the medical center's community living center, emergency department, and primary care clinic, which is locally known as the Green clinic. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* requires staff to store soiled or contaminated items separately from clean or sterile supplies to prevent cross-contamination and the spread of infection.²⁰ The chief of environmental management services acknowledged that staff stored the items improperly but did not offer a reason.

In December 2025, the OIG team requested an update on how staff store soiled and clean items, and executive leaders reported that staff on each unit had created clearly marked storage areas to separate clean supplies and soiled equipment. Leaders also said that supply chain management, engineering, and infection control team members now inspect these areas weekly to ensure compliance. In January 2026, the engineering service chief provided the OIG with Environment of Care Committee minutes that also showed staff stored clean and soiled items separately. Because staff implemented corrective actions and demonstrated improvement, the OIG did not make a recommendation.

During the April 2025 inspection, the OIG team also noted concerns with several portable fire extinguishers at the health care center. Some fire extinguisher inspection tags had an inaccurate date listed, which conflicts with the requirement for complete and accurate monthly inspection records in the Joint Commission *Standards Manual*, EC [Environment of Care] standard 02.03.05.²¹ Incomplete or incorrect inspection documentation could compromise staff's ability to determine whether fire extinguishers are safe to use. The safety manager said the property owner was responsible for these inspections because the health care center is a leased space.

In December 2025, executive leaders reported that facility staff now have a monthly call with the health care center lessor to confirm completion of required equipment tests and inspections, and that safety staff also started weekly random fire extinguisher checks to verify compliance. In January 2026, the engineering service chief submitted fire extinguisher inspection reports for November and December 2025 that confirmed compliance. As a result, the OIG did not make a recommendation.

During the April 2025 visit, inspectors also found several patient beds in the medical center's emergency department with preventive maintenance stickers that did not show evidence staff had inspected and tested the beds. The stickers either had no date listed or showed an overdue inspection date. Additionally, blood pressure machines had outdated stickers, and a patient lift on

²⁰ VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

²¹ The Joint Commission, *Standards Manual*, E-dition, EC.02.03.05, March 30, 2025.

the medical center's surgical inpatient unit needed repair. The Joint Commission *Standards Manual*, EC.02.04.03, requires that staff inspect and test medical equipment to ensure it is safe and operational.²² Delayed repairs and unclear maintenance status can place patients and staff at risk if the equipment fails during use.

In December 2025, executive leaders reported that nursing staff now inspect equipment before use and remove items from service when repairs are needed, and that Environment of Care Committee members review preventive maintenance stickers during weekly rounds to ensure equipment is safe and operational. In January 2026, the engineering service chief provided the OIG with evidence that leaders implemented a standardized process for facility staff to submit maintenance and repair work orders to the engineering service. These corrective actions addressed the issues, so the OIG did not make a recommendation.



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

VHA Directive 1088, *Communicating Test Results to Providers and Patients* (published in July 2023), required facilities to develop and implement a local policy within 6 to 12 months from the publication date.²³ However, executive leaders did not update their local policy until April 2025. Staff acknowledged they updated their existing local policy only after learning the OIG would review it during the current inspection. According to the chief of quality management, staff knew they needed to develop and implement a local policy consistent with VHA's updated directive, but the chief did not provide a reason for the delay.

However, the local policy did not address abnormal results that may be life-changing—such as a test suggestive of a cancer diagnosis—for patients at high risk for suicide, nor did it include written workflows for each service that describe team members' roles in the process to communicate test results.²⁴ In June 2026, the OIG requested a status update, and the Chief of Staff provided a copy of the local communication of test result policy; however, the policy still did not meet VHA Directive 1088(1) guidance. Therefore, the OIG made two recommendations.

²² The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, March 30, 2025.

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

²⁴ VHA Directive 1088(1).

Recommendation 1

The Director takes appropriate actions so leaders update the facility's policy for communicating test results to include how providers communicate life-changing results to patients at high risk for suicide, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The facility's policy, SOP 011-014, "Communicating Test Results to Providers and Patients," has been thoroughly reviewed and revised to ensure full alignment with Veterans Health Administration Directive 1088(1). The updated policy was signed on September 1, 2026, and made accessible to all staff via the facility's SharePoint as of September 2, 2026.

Notably, the revised SOP incorporates guidance under the section addressing special circumstances, in concordance with the VHA Directive as noted in the OIG HFI report. This includes clear procedures for communicating life changing test results to patients identified as high risk for suicide, underscoring the facility's ongoing commitment to suicide prevention and patient centered care. Leadership has ensured that relevant staff are informed of these changes and that implementation processes are in place to monitor compliance.

The facility requests closure of this recommendation.

OIG Comments

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

Recommendation 2

The Chief of Staff and Associate Director for Patient Care Services develop workflows that describe how each team member participates in the process to communicate test results, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: September 30, 2026

Director Comments

The facility's policy, SOP 011-014, "Communicating Test Results to Providers and Patients," has been thoroughly reviewed and revised to ensure full alignment with Veterans Health Administration Directive 1088(1). The updated policy was signed on September 1, 2026, and made accessible to all staff via the facility's SharePoint as of September 2, 2026.

In collaboration with the Chief of Staff and the Associate Director for Patient Care Services, it was determined that a single, standardized detailed workflow will be utilized by all service lines as the accepted workflow across the service lines. This workflow clearly defines the roles and responsibilities of all team members involved in the communication of test results, including providers and support staff. The standardized workflow was incorporated into the SOP to ensure a consistent, Medical Center-wide approach to the timely and appropriate communication of test results. The workflows are accessible in the Central Virginia HCS On-Call folder within the respective service directories.

To further streamline and standardize the communication process, the Richmond On-Call system has been designated as the principal pathway for both disseminating on-call schedules and facilitating timely communication of test results notification. Staff have been informed of these changes, and necessary training has been provided to ensure seamless implementation.

The facility requests closure of this recommendation.

OIG Comments

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

Additionally, the chief of quality management said the facility uses data from the External Peer Review Program to monitor test result communications.²⁵ Quality management staff reported reviewing the external review program measures quarterly in the Quality and Patient Safety Executive Council.

The chief of quality management said facility staff recognized that external peer review data includes only a small number of patient records, so beginning in January 2025, staff reviewed 50 additional laboratory and radiology service electronic health records monthly. The interim

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).

chief of primary care said facility leaders also monitor test result communication through electronic health record audits during providers' Ongoing Professional Practice Evaluations.²⁶

Action Plans and Process Improvements

The OIG team did not find issues related to test result communication from oversight and accreditation reports over the past three years. At the time of the inspection in April 2025, the facility had not completed corrective actions for one open recommendation from an April 25, 2024, OIG comprehensive healthcare inspection report, which involved out-of-range temperature and humidity levels for reusable medical equipment storage.²⁷ The chief of engineering discussed a policy to ensure staff monitor areas where they store reusable medical equipment. The team did not find any issues with temperature and humidity monitoring, and facility staff said they were addressing the open recommendation from the prior report. Staff submitted information in December 2025 that showed they had corrected the temperature and humidity issue, and the recommendation was closed in January 2026. Therefore, the OIG did not make a recommendation.

Quality management staff reported that facility staff enter patient safety events into VHA's Joint Patient Safety Reporting system (a database used to report patient safety events).²⁸ They also said current executive leaders support process improvement projects, and staff faced no barriers to initiating projects.



PRIMARY CARE

The OIG assessed whether primary care teams were staffed in compliance with VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.²⁹ The OIG interviewed staff, analyzed primary care team staffing data, and examined new patient appointment wait times.

²⁶ Ongoing Professional Practice Evaluations regularly check a clinician's performance to make sure they provide safe, high-quality care, using things like observations, discussions, and reviews that are specific to the provider. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

²⁷ VA OIG, [Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond](#), Report No. 23-00104-134, April 25, 2024.

²⁸ VHA National Center for Patient Safety, *JPSR Guidebook, Version 6.0*, October 2025.

²⁹ VHA Directive 1406(3); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

Primary Care Teams

The facility has 71 primary care teams. In March 2025, the deputy chief of primary care provided the OIG with a document showing there were several vacant provider and support staff positions at the medical center and health care center, and that leaders were recruiting candidates to fill some of them. The principal facility coordinator said recent retirements and resignations contributed to provider vacancies. The Chief of Staff added that the health care center opened one month before the OIG's visit in April 2025, and executive leaders planned a phased expansion over five to seven years.

Executive leaders reported an additional recruiting challenge: after they extended job offers, many candidates either declined at the last minute or did not attend new employee orientation, and some expressed concerns about a potential reduction in force as a reason for declining. A primary care leader also noted that despite incentives, such as increased location pay and debt reduction assistance, it was difficult to compete with the salaries offered by local private hospitals.

A primary care leader said medical support assistant positions have a high turnover rate, and at the time of the inspection, the facility relied on contracted staff to fill vacancies. In June 2026, the Chief of Staff reported that medical support assistant positions continued to have high turnover, and to maintain adequate coverage, the facility still used contracted staff to support patient scheduling and ensure continuity of operations. The chief said leaders were monitoring staffing levels, supporting recruitment efforts, and assessing workload distribution to address ongoing turnover challenges and reduce the impact on patient access.

Further, a social worker reported vacancies in primary care social worker positions, explaining that this sometimes results in social workers being unable to meet with veterans when they come for a scheduled appointment. In response, social workers opened a same-day walk-in clinic for patients with urgent needs. They also review patient appointments for the upcoming week to identify high-risk cases and proactively reach out to the veteran to assist. Additionally, leaders reassigned two social workers from other areas to support the primary care clinic.

A primary care leader discussed how staff manage new patient visits. Nurses contact patients within two weeks of their first scheduled visit, collect their medical history, and order laboratory tests. This approach allowed primary care teams to shift from 60- to 30-minute new patient appointment times. As a result, the OIG found new patients waited an average of 38 days for appointments in FY 2025, and 33 days as of May 2026. Primary care staff explained that provider vacancies negatively affected wait times and stated that staff offer patients the option of care in the community when the wait time is over 20 days. The Code of Federal Regulations, title

38, section 17.4040, states that veterans may be referred to community providers if the wait time for a primary care appointment is longer than 20 days.³⁰



VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

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

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.³² 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).³³ 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 38 C.F.R. § 17.4040 (2025).

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

³² 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.

³³ VHA sets targets for HCHV1 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*. 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.

rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits).”³⁴

Performance and Improvement Highlights

- The facility program met the intake percentage (HCHV5) target level from FY 2024 up to the time of the inspection visit in April 2025. The homeless veterans program manager attributed the improvement to increased staffing, which allowed program staff to audit the intake list to ensure they accurately entered assessments in VHA’s national database.
- Staff reported they conduct outreach at shelters and work with community partners to maintain a list of individuals experiencing homelessness in the area, which they use to identify veterans. They then contact the veterans, conduct assessments, enroll them into the program, and refer them to additional VA services if needed.
- The facility program met the discharge to permanent housing (HCHV1) target in FY 2024 and the first quarter of FY 2025. Although the program missed the negative exit (HCHV2) target in FY 2024, it met the target in the first quarter of FY 2025. Staff said the number of contract emergency residential beds is limited, and a single discharge can result in missing the target. The outreach coordinator added that some veterans work night shifts, which prevents them from being at the contract facility overnight and results in a rule violation and discharge.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including “serious mental illness, physical health diagnoses, and substance use disorders.”³⁵ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³⁶

VHA measures how well the program meets veterans’ needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by

³⁴ VHA 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*.

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

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

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

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target for FY 2024 or the first quarter of FY 2025. Staff identified changes in the affordable housing inventory and increases in the cost of living as barriers to meeting the target. The program supervisor reported that, to increase housing options, a housing specialist engages potential landlords to educate them about the program.
- The program met the employment (VASH3) target for FY 2024 and the first quarter of FY 2025. Program staff attributed their success to the employment specialists, who identify potential employers willing to hire veterans. The specialists also refer veterans to the compensated work therapy program.³⁸
- The program supervisor said housing specialists facilitate group sessions called Pathways to Stability, designed to teach veterans the skills they need to maintain permanent housing. They educate veterans about rental insurance, apartment leasing, legal assistance, budgeting, and safety in the home. Staff also reported strong relationships with community partners, who assist veterans by paying for application fees, rental deposits, photo identification, and birth certificates.

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.³⁹ 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).⁴⁰

³⁷ VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility’s program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

³⁸ Compensated work therapy “provides evidence based and evidence informed vocational rehabilitation services for veterans as well as other supports and partnerships for employment.” “Compensated Work Therapy,” VA, last updated June 15, 2026, <https://department.va.gov/vha/cwt>.

³⁹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁰ VHA sets escalating targets for this measure at the facility level each year, with the goal 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*.

Performance and Improvement Highlights

- The facility program met the enrollment (VJP1) target for FY 2024 and the first quarter of FY 2025. Program staff attributed this success to a veteran outreach specialist who performs outreach at jails in Henrico County, which increased veteran engagement and enrollment.
- The outreach staff said they receive referrals from probation officers, court personnel, defense attorneys, and veterans' family members. The reentry specialist described how federal prison staff use the Veterans Re-Entry Search Service system to identify and connect veterans to the program.⁴¹ After they receive referrals, the specialists meet with veterans, complete program entry assessments, determine the veterans' initial needs, and refer them for VA or community resources.
- Additionally, outreach staff reported they train police officers and first responders to identify veterans in crisis and refer them to VA for services. They also submit veterans' documents to the Veterans Benefits Administration to restart benefits after release from prison.

Conclusion

To assist leaders in evaluating the quality of care at the Richmond facility, the OIG conducted an inspection across five domains. The OIG made two recommendations related to test result communication. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 1. 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.

⁴¹ The Veterans Re-Entry Search Service (VRSS) is a secure VA tool that correctional facilities and courts use to identify veterans in their custody. The tool helps VA outreach programs connect the veteran with VA programs. "Welcome to the Veterans Re-Entry Search Services," VA, last updated September 1, 2010, <https://vrss.va.gov>.

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.⁴² 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 the facility from April 22 through 24, 2025; contacted facility staff in December 2025, January 2026, and June 2026 to obtain updated information; and reviewed primary care patient wait time data in May 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.⁴³ 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*.⁴⁴

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁴⁵ 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.

⁴² 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.

⁴³ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁴⁴ 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.

⁴⁵ 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 1978.⁴⁶ 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.

⁴⁶ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 15, 2026

From: Executive Director, Health Service Area 2.1, VHA (10N6)

Subj: Healthcare Facility Inspection of the Central Virginia VA Health Care System in Richmond

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

1. Thank you for the opportunity to review the draft report for the Central Virginia VA Health Care System. I have reviewed and concur with the recommendations provided by the VA Office of Inspector General (OIG), as well as the action plan provided by the facility. I concur with the request to close recommendations #1 and #2.
2. In our ongoing commitment to ensuring Veterans receive exceptional care, HSA 2.1 leadership confirms that all policy development actions outlined in the responses have been fully implemented and will continue to be maintained.

(Original signed by:)

Alyshia Smith, DNP
Executive Director, Health Service Area 2.1

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 4, 2026

From: Acting Executive Director, Central Virginia VA Health Care System (652/00)

Subj: Healthcare Facility Inspection of the Central Virginia VA Health Care System in Richmond

To: Executive Director, Health Service Area 2.1, VHA (10N6)

1. Thank you for the opportunity to review and comment on the VA Office of Inspector General's (OIG) draft report, Healthcare Facility Inspection of the Central Virginia VA Health Care System in Richmond.
2. The Central Virginia VA Health Care System leadership team concurs with recommendations 1 and 2 and have implemented corrective actions to address the identified findings and strengthen processes related to communication of test results.
3. Should you need further information, please contact the Chief of Staff.

(Original signed by:)

James W. Dudley, Jr.

Acting Executive Director

OIG Contact and Staff Acknowledgments

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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.