US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Milwaukee Healthcare System in Wisconsin

Healthcare Facility Inspection	25-00249-275	September 25, 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 VA Milwaukee Healthcare System (the facility) from June 10 through 12, 2025. Additionally, the OIG team contacted facility staff in December 2025 and July 2026 for updates. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 63,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG determined that a local policy for test result communications existed in July 2026, but had not been approved and implemented, and leaders had not developed service-level workflows, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] The OIG made one recommendation.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.

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[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] 12) Clement J. Zablocki Veterans' Administration Medical Center*, last updated February 10, 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.

[4] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate action so leaders update their local policy and develop service-level workflows for test result communications, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the finding and recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C for the full text of the directors' comments).[5] Based on information provided, the OIG considers the recommendation closed.

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

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
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 Milwaukee Healthcare System (the facility) consists of the Clement J. Zablocki VA Medical Center (the medical center) and five community-based outpatient clinics. The medical center's site originally housed the Milwaukee Soldiers Home, now a National Historic Landmark, which admitted 60 Union soldiers in 1867. Since then, the facility has grown to include 187 hospital, 125 domiciliary, 110 community living center, and 9 compensated work therapy beds.[11] In fiscal year (FY) 2025, it had a budget of approximately $1.1 billion and served around 63,000 veterans.[12]

Figure 1. *Facility photo.*
Source: "VA Milwaukee Health Care," VA, accessed June 30, 2025, https://www.va.gov/milwaukee-health-care/locations.

The OIG team inspected the facility from June 10 through 12, 2025, and contacted facility staff in December 2025 and July 2026 to obtain updated information. The executive leaders referred to throughout this report include the Medical Center Executive Director (Director) and Associate Director, appointed in April and August 2023, respectively; the Chief of Staff and Associate Director for Patient Care Services (ADPCS), permanently assigned February 2024 and May 2025, respectively; and the Assistant Director, the most tenured, who started in October 2017. An acting ADPCS temporarily covered the role while the permanent leader was absent during the week of the inspection.

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.[13] The OIG administered its

[11] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/homeless/dchv. 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/VA_CLC. 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. VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) Clement J. Zablocki Veterans' Administration Medical Center*, last updated February 10, 2026.

[12] VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 12) Clement J. Zablocki Veterans' Administration Medical Center*, last updated February 10, 2026.

[13] 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.

own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

System Shocks

Executive leaders identified two system shocks in the three years before the inspection in June 2025: a flood in the facility's operating rooms in November 2023, and the impacts of January 2025 executive orders and memoranda related to a hiring freeze (in effect from January 20, 2025, to October 15, 2025), return to in-person work mandate, potential reductions in force (layoffs), and a deferred resignation program.[16] The flood affected three operating rooms and caused extensive water damage to equipment, supplies, and flooring. According to a facility report, employees rescheduled 18 surgical procedures, yet executive leaders stated there were minimal negative effects on patient care.

The flood had substantial operational and financial consequences. The chief of quality management reported that employees had to reprocess over 92,000 pieces of medical instrumentation due to contamination while leaders worked with the Veterans Integrated Service Network (VISN) to replace supplies.[17] Cleanup and recovery cost the facility nearly $1 million,

[14] "Veteran Trust in VA," VA, last updated January 20, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[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.

[16] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025. Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative, 90 Fed. Reg. 9669 (Feb. 14, 2025). "Original Email to Employees," Office of Personnel Management, January 28, 2025, https://www.opm.gov/about-us/fork/original-email-to-employees.

[17] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "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.

including overtime pay and equipment replacement. During the flood response, leaders said they relied on employee expertise and met with them twice daily to promote team communications. The facility returned to normal operations in approximately 14 days. Leaders attributed the recovery to a new communication process with subject matter experts—designed to reach consensus on next steps—as pivotal to the facility's successful efforts. They also described holding the first-ever Safety Panel, which involved staff sharing lessons learned and identifying improvement opportunities. According to leaders, the panel increased transparency and strengthened a culture of learning and shared responsibility for safety.

Executive leaders also reported the engineering service lost 13 employees to the deferred resignation program and could not fill eight vacancies due to the hiring freeze in place at that time. The service operated with only 2 administrative employees responsible for purchasing, timekeeping, and contract management because there were four vacancies in this position. Leaders said employees took on additional duties, prioritized essential tasks, shifted some weekly duties to monthly, and conducted some preventive maintenance tasks less frequently. Although department leaders prioritized patient care, they expressed concern about long-term sustainability if vacancies continued. Leaders acknowledged they carefully monitored and assessed staffing levels in each service to maintain facility operations and ensure patient safety.

Executive leaders also stated that employees expressed anxiety about job security and had questions about how the January 2025 changes would affect them. To manage the effects on organizational culture, leaders prioritized transparent communications and employee support. The Director noted they held several large-scale town halls, and about 2,000 employees participated—a significant portion of the workforce. These sessions provided a platform for leaders to explain what they knew about the new mandates, clarify issues that remained uncertain, and reassure employees they were not making plans behind the scenes and were committed to keeping them informed.

To make themselves highly visible and accessible, leaders regularly walked around medical center units, talked to employees, and personally responded to concerns. They often reached out to employees directly, sometimes outside of work hours, to correct misinformation and ease staff's anxiety.

Employee Experiences

In addition to the large-scale town halls, executive leaders said they also held monthly town halls at the time of the inspection in June 2025, including during evening and night shifts. Leaders shared that they previously only invited service chiefs to monthly facility operational meetings but began inviting supervisors as well so they would have access to the same information. Additionally, leaders launched tiered huddles (brief meetings held at multiple levels) in April 2025 to improve the communication flow between frontline employees and executive leaders. OIG questionnaire respondents described executive leader communications as clear,

useful, and frequent, and more than half said changes were an improvement over previous communication efforts. The respondents also largely indicated the facility's culture was moving in the right direction, as shown in figure 2.

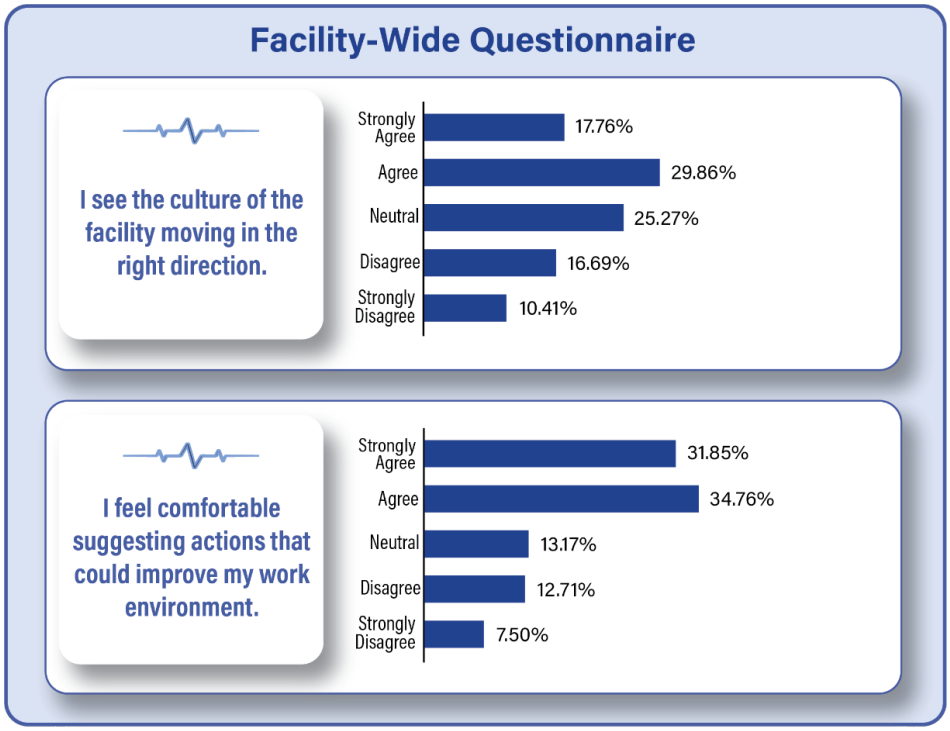

Figure 2. *Employees' perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Leaders also empowered employees to share examples of near misses (errors that employees discover and correct before a patient is harmed) during town halls to foster psychological safety across the organization.[18] According to an executive leader, when employees openly disclose their mistakes and lessons learned, it demonstrates trust and a culture that values transparency over blame.

Veteran Experiences

Patient advocates indicated that veterans' most common complaints were about community care. The Director also said that veterans specifically complained about eligibility for services such as massage therapy. In response, medical center employees developed letters to send to veterans whose requests for massage therapy were denied to offer them options for alternative care, such

[18] "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.

as a functional rehabilitation group (which helps to manage chronic pain through education, lifestyle, and behavioral changes).[19]

When asked about these issues, the Director emphasized the importance of veterans' input. In addition to patient advocates, employees collected feedback through multiple channels, such as hallway conversations with veterans and town halls. The leader said town halls with veterans were virtual and held quarterly, often with over 1,000 participants. Executive leaders said they reviewed all concerns raised in town halls and worked with employees to implement actions to resolve them.

Attention to environmental design improves veterans' and staff's safety and experience.[20] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[21]

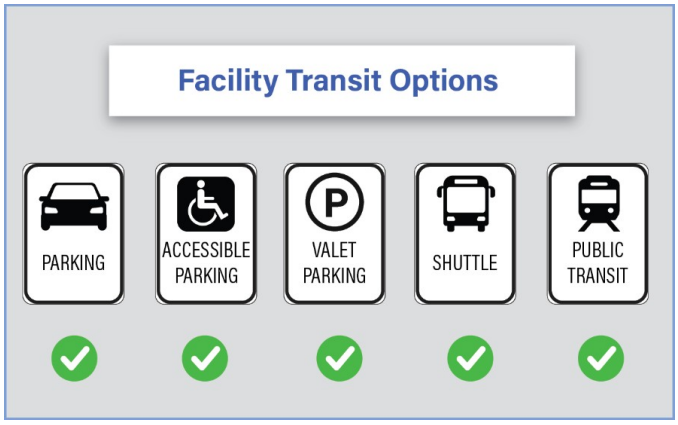

Figure 3. *Transit options for arriving at the facility. Source: OIG inspector observations and interview with facility staff.*

General Inspection

On arrival, the OIG team observed a patient pickup and drop-off zone with a covered awning for protection from the weather. A combination of garage and parking lot options offered ample accessible spaces for those with disabilities. Additionally, the

[19] VA, "Veterans Suffering from Chronic Pain Find Relief Through Functional Rehabilitation Group," July 10, 2024, https://www.va.gov/milwaukee-health-care/stories/vefunctional-rehabilitation-group.

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

[21] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

team observed emergency call systems, large-font signs, and several security cameras in the parking areas.

Figure 4. *Accessibility tools in use for veterans with impairments.*
Source: OIG inspector observation and interview with facility staff.

The main entrance featured power-assisted doors and wheelchairs for veterans to use if needed. The area was well-lit, with multiple information desk cubicles (greeting stations). The team noted the large number of people in the main entrance created elevated noise levels, although the area had sound-absorbing ceiling tiles. This environment may pose difficulties for veterans with sensory impairments.

As to other positive features, the team observed a facility directory at the main entrance, braille on exam room doors, and audio instructions in the elevators. Inspectors used the directory to find designated locations without difficulty and noted large-font signs in parking areas. Although the team noticed televisions in waiting areas did not have closed captioning on to assist veterans with hearing impairments, staff did take other measures. Staff explained that they communicate with hearing-impaired veterans by writing instructions. They also escort veterans to their appointments or throughout the facility as needed.

The OIG team inspected the intensive care and medical-surgical units, primary care clinic, emergency department, and community living center. Inspectors observed wall damage and found dust and debris in air vents in the patient care areas inspected and throughout hallways. VHA Directive 1850, *Environmental Programs Service* requires staff to keep all patient areas clean and safe.[22] Unpatched holes and dirty air vents can allow contaminants to enter the environment, which increases the risk of infection for veterans and staff. The environmental management services chief explained staffing vacancies at the time of the inspection in June 2025 led to inconsistent cleaning schedules.

In July 2026 the OIG reviewed facility data provided by the accreditation specialist and confirmed that facility-wide auditing and monitoring processes started in March 2026 and June 2026, respectively. Therefore, the OIG did not make a recommendation.

[22] VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.

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

Communication of Urgent but Noncritical Test Results

The facility's policy for communicating test results, last approved in June 2020, did not align with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, and the facility did not have written service-level workflows that define team members' roles in the communication process. The directive, issued in July 2023, required facility directors to ensure staff revise the local policy within 6–12 months of publication and develop written service-level workflows.[23]

The Chief of Staff and the acting ADPCS, who are responsible for workflow development, did not ensure staff completed this work, although the acting ADPCS acknowledged receiving notification of the update to VHA Directive 1088(1). An outdated policy and the absence of workflows for staff to communicate test results heighten the risk that patients may not promptly receive abnormal results and delay diagnosis or treatment.

In December 2025, the chief nurse of ambulatory care reported that executive leaders directed a workgroup to standardize workflows for all outpatient services, revise the local policy, and update them on the progress. Leaders planned to test the workflows and finalize the local policy after the testing was complete. In July 2026, the OIG followed up, and the accreditation specialist reported that the new policy had been created but had not yet been approved or implemented.

Recommendation 1

The Director takes appropriate action so leaders update their local policy and develop service-level workflows for test result communications, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

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

Director Comments

The Medical Center Director has ensured that the organization has completed an update the internal policies related to the communication of both critical and non-critical test results to provide a clearer tool for staff that aligns fully with VHA Directive 1088. This includes the development of service level workflows, as required per the Directive, for all impacted clinical teams. The policy revisions and the workflows were completed collaboratively with the Chief of Staff and Nursing Leadership. This new guidance has been presented to/shared with all involved staff members. The organization requests closure at this time.

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.

Facility staff said providers or designees who ordered tests received urgent but noncritical test results through view alerts (electronic notifications in a patient's medical record that require a provider's action) at the time of the inspection in June 2025. From a document review and staff interview, the OIG team learned that providers did not address almost 300 alerts from a provider who left the facility in April 2024 (more than a year prior). The acting ADPCS reported that when leaders became aware of the issue in May 2024, they assigned a provider to review the alerts, and staff entered adverse events into the patient safety reporting system (a VA database) for follow-up.[24]

At the time of the OIG inspection in June 2025, leaders had not implemented a process to validate that departing providers had surrogates assigned. When providers have an extended absence or leave the facility, VHA Directive 1088(1) requires leaders to assign another provider (a surrogate) to address their alerts. If providers do not address alerts, patients' serious conditions may be untreated. The associate chief of staff for education submitted updated information in December 2025 that explained leaders access a database to verify that a departing provider has an assigned surrogate before they leave. Therefore, the OIG did not make a recommendation.

VHA Directive 1088(1) requires patients to be notified of tests results that require action within seven days from the date results were available to the provider or designee. The OIG team found that the ADPCS did not review the facility's data on test result communications, as mandated by the directive. A registered nurse performance facilitator reported emailing External Peer Review Program results to specific staff.[25] However, the ADPCS was not included in these

[24] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, March 18, 2026.

[25] The external review is a process that supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. VHA Office of Informatics and Analytics, "External Peer Review Program (EPRP)," March 15, 2022.

communications. Without access to the results, the ADPCS may miss opportunities to oversee performance and ensure timely notification of test results.

In July 2026, the accreditation specialist shared that, effective July 2, 2026, quality management staff report results from the External Peer Review Program to the Medical Executive Committee. Because the ADPCS now has access to review and monitor data on test result communications, the OIG did not make a recommendation.

Action Plans and Process Improvements

The OIG team reviewed the facility's approach to managing patient safety events. Patient safety managers described a process centered on the facility's service-level responsibilities, oversight by patient safety managers, and support from quality management staff and executive leaders. The managers reported they generally consider an event resolved once facility staff confirm the actions are complete. For issues with broader operational implications or greater risk, quality management staff and patient safety managers monitor implementation more closely through regular meetings or committee oversight.

Quality management staff identified opportunities for improvement through morning meetings, patient safety event reports, and environment of care rounds.[26] They stated they reviewed the status of action plans with the Director monthly and reported no actions were overdue at the time of the inspection in June 2025. Staff described leader support for improvement efforts, noting active participation in process improvement work during FY 2025. They also referenced ongoing multi-workgroup initiatives focused on enhancing patient transitions across outpatient, emergency department, and inpatient settings.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[27] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

[26] Environmental rounds "are recurring facility tours used to manage environmental risk through the pro-active identification of unsafe conditions or non-compliance." VHA Directive 1608(1).

[27] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

Primary Care Staffing and Access to Care

The facility offers primary care at the medical center and all five community-based outpatient clinics, with a total of 102 primary care teams. At the time of the inspection in June 2025, staff vacancies included two providers, four registered nurses, five licensed practical nurses, and multiple medical support assistants. Despite the vacancies, facility data from January 2024 through March 2025 showed that primary care staffing ratios were consistent with guidelines in VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* for three full-time equivalent support staff for each provider.[28]

The OIG team found that veteran enrollment was steady from FYs 2023 through 2024. Inspectors determined the average new patient wait time was approximately 18 days from October 2023 through March 2025. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is longer than 20 days.[29]

The team also reviewed a list of process improvement projects provided by staff. In one example, a primary care nurse described an effort to increase the number of home colorectal cancer screening tests returned by patients. The nurse explained staff used both letters and a VA text messaging service (called Annie) to remind patients to return tests.[30] Since they started the project nine months previously, in September 2024, there was a 58 percent increase in returned home tests. Additionally, as more staff complete training on Annie, primary care nurses plan to use it to help manage other long-term health conditions.

Community Care Staffing and Access to Care

Community care staff took an average of 21 days to schedule patients' first appointments with community providers in FY 2025. VHA's *Consult Timeliness Standard Operating Procedure* requires staff to schedule appointments within 7 days of receiving a referral for community care.[31] A nurse manager explained in June 2025 that limited administrative support affects how quickly staff can complete referral processes, such as sending authorizations to community providers and scheduling appointments. Community care leaders also reported that the loss of VA providers contributed to increased reliance on community care.

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

[29] 38 C.F.R. § 17.4040 (2025).

[30] "VA Mobile, Annie for Clinicians," VA, accessed July 1, 2025, https://mobile.va.gov/app/annie-clinicians.

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

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.[32]

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.[33] 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).[34] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program

Figure 5. *Community Resource and Referral Center.*
Source: OIG interview with HCHV leaders and staff.

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

[33] 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.

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

requirements…or [who] left the program without consulting staff (referred to as negative exits)."[35]

Performance and Improvement Highlights

- The facility program did not meet the intake assessment (HCHV5) target for the first two quarters of FY 2025. Program staff attributed this to seasonal factors and anticipated additional engagement during the summer months when veterans are more available at outreach locations.
- The facility missed the exit to permanent housing (HCHV1) target in the first two quarters of FY 2025, but met its negative exit (HCHV2) target during the same period. The HCHV lead explained that performance for both measures varies because the program has only six contracted emergency residential service beds, so either type of exit greatly affects the metric. Staff stated they work with the contracted emergency residential services liaison to address issues that lead to negative exits, such as veterans violating program rules.

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."[36] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[37]

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).[38]

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target in the first two quarters of FY 2025. The facility program coordinator explained that landlords

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

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

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

[38] 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.*

hesitated to rent to veterans with poor credit or a history of evictions. Other staff described challenges at that time with housing agencies that did not return to pre-pandemic functioning, which limited or slowed veterans' use of vouchers. In response, staff worked to increase landlord engagement through outreach and training events and met regularly with housing agencies and VISN homeless program leaders to address concerns.

- As of June 2025, program staff said approximately 65 percent of enrolled veterans were 60 years of age or older and needed support to keep them housed independently as they age. Staff worked with the facility's Geriatric and Extended Care program and VISN leaders through the Homeless Aging and Disabled Veterans Initiative to help identify services and develop potential housing opportunities for aging veterans, such as using vouchers in homes that offer caregiver services.[39] The program's occupational therapists provided home safety assessments, education, and medical equipment to assist veterans with daily activities, such as bathing and medication management, to help them live independently longer.
- The program was meeting the employment (VASH3) target in the first two quarters of FY 2025, and staff attributed the success to effective collaborations among program coordinators, the facility's homeless veterans community employment specialist, vocational rehabilitation counselors, and peer support specialists, as well as support from community employment programs.

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.[40] 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).[41]

[39] "VA Homeless Programs, Homeless Aging and Disabled Veterans Initiative," VA, accessed June 27, 2025, https://www.va.gov/homeless/aging-disabled-veterans-initiative.

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

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

Performance and Improvement Highlights

- The facility fell short of the enrollment (VJP1) target for the first two quarters of FY 2025. Facility program staff said the scores did not reflect the assistance they provide to veterans, including those who are not eligible for VA health care. They noted it was time intensive to conduct care coordination for veterans in treatment courts (long-term, judicially supervised programs where they receive treatment and other services monitored by a judicial team), which limited enrollment growth.[42]
- Staff reported that some veterans—especially those in rural areas—struggle to attend outpatient appointments due to limited transportation. To help, staff recommended virtual care options, referred veterans to community care services, and connected them with county veteran transportation services (although veterans can only use it two or three times to briefly meet the need). Staff agreed that veterans who lack transportation would benefit from programs that pay for rideshare services.

Conclusion

To assist leaders in evaluating the quality of care at the VA Milwaukee Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to test result communications. Facility leaders have started to implement corrective actions, which resulted in the OIG closing the recommendation. The OIG's findings and recommendation 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.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from June 10 through 12, 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.[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.

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

[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.

[46] 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: September 10, 2026

From: Network Director, Veterans Integrated Service Network (VISN) 3

Subj: Healthcare Facility Inspection of the VA Milwaukee Healthcare System in Wisconsin

To: Director, Office of Healthcare Inspections (54HF05)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and provide a response to the draft report, Healthcare Facility Inspection of the VA Milwaukee Healthcare System in Wisconsin.
2. I concur with the findings and recommendations identified by OIG, and the corrective action plans submitted by the facility.
3. I would like to thank the OIG inspection team for their review of the VA Milwaukee Healthcare System.

(Original signed by:)

Daniel S. Zomchek, Ph.D.
Veterans Integrated Service Network 3 Director, Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 1, 2026

From: Director, VA Milwaukee Healthcare System (695)

Subj: Healthcare Facility Inspection of the VA Milwaukee Healthcare System in Wisconsin

To: Director, VISN 3 (10N3)

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Healthcare Facility Inspection of the VA Milwaukee Healthcare System in Wisconsin.
2. A corrective action plan has been implemented as detailed in the attached report.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.
4. Should you need any further information, please contact the Chief for Quality, Safety, and Value.

(Original signed by:)

James McLain, FACHE
Executive Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Catherine McNeal-Jones, MSN, RN, Team Leader Carol (Shannon) Foote, MSN, RN Mandy Petroski-Moore, LCSW
Other Contributors	Kevin Arnhold, FACHE Shelby Assad, LCSW Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS Dan Zhang, MSC

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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.