



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Maryland Health Care System in Baltimore

Healthcare Facility
Inspection

26-00044-209

October 19, 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 three medical centers of the VA Maryland Health Care System (the facility) from May 11 through 14, 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to nearly 65,000 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 team found that some bathroom and shower pull cords (emergency call devices to signal for help) were missing or inaccessible from the ground, which did not align with the National Fire Protection Association's *NFPA 99 Health Care Facilities Code*.³ The OIG made a recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. Inspectors found the facility had service-level workflows for some but not all services that send or receive test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.⁴ The OIG made a recommendation.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process

¹ VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "VHA Facility Complexity Model History," VHA Support Service Center, accessed July 14, 2026, <https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer>. (This web page is not publicly accessible.)

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

³ The National Fire Protection Association, *NFPA 99 Health Care Facilities Code*, 2024 ed., 7.3.3.1.2.5 and 7.3.3.1.6(3), September 14, 2023.

⁴ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

improvements.⁵ The OIG found that the facility lacked a standardized process to routinely assess primary care panel sizes (the number of patients assigned to a care team) and efficiency, in accordance with VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.⁶ The OIG also found that leaders had not ensured the facility met the seven-day community care scheduling requirement in VHA's *Consult Timeliness Standard Operating Procedure*.⁷ The OIG made two 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 team identified staff security concerns at the Baltimore VA Clinic. The OIG made a recommendation.

What the OIG Recommended

1. The Associate Director requires bathroom and shower emergency pull cords to be present, accessible, and functional, in accordance with the National Fire Protection Association's *NFPA 99 Health Care Facilities Code*.
2. The Chief of Staff develops written workflows for each service consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
3. The Chief of Staff develops and implements a standardized process to routinely assess panel size and efficiency, as required by Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.
4. The Director develops and implements a process to meet the seven-day scheduling requirement in Veterans Health Administration's *Consult Timeliness Standard Operating Procedure*.
5. The Director considers a security assessment to identify risks at the Baltimore VA Clinic, in accordance with VA Handbook 0730, *Security and Law Enforcement*.

⁵ VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

⁶ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

⁷ VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated October 2, 2025.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments).⁸ Based on information provided, the OIG considers all recommendations to be closed.



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⁸ In December 2025, VA announced plans to reorganize the management structure of VHA. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>.

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Executive Summary	i
Introduction.....	1
Culture.....	2
Environment of Care	7
Recommendation 1.....	9
Patient Safety	10
Recommendation 2.....	10
Integrated Veteran Care	12
Recommendation 3.....	13
Recommendation 4.....	15
Veteran-Centered Safety Net	16
Recommendation 5.....	17
Conclusion	21
Appendix A: Methodology	22
Appendix B: VISN Director Comments	24
Appendix C: Facility Director Comments	25
OIG Contact and Staff Acknowledgments	26
Report Distribution	27



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.⁹ 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.¹⁰



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.¹¹



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.¹²



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.¹³

⁹ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

¹⁰ 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>.

¹¹ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

¹² VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹³ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Maryland Health Care System (the facility) includes two medical centers in Baltimore and one in Perry Point, as well as six outpatient clinics.¹⁴ The OIG team inspected the facility from May 11 through 14, 2026. Its fiscal year (FY) 2025 operating budget was approximately \$745 million, and it had 366 operating beds across the medical centers (140 community living center, 17 hospice, 85 inpatient acute care, 14 inpatient mental health, and 110 domiciliary).¹⁵



Figure 1. Baltimore VA Medical Center, Perry Point VA Medical Center, and Loch Raven VA Medical Center (left to right).

Source: “VA Maryland Health Care,” VA, accessed June 8, 2026, <https://www.va.gov/maryland-health-care>.

The executive leaders referred to throughout this report included the Director, Chief of Staff, Deputy Director, Associate Director for Patient Care Services/Chief Nurse Executive, Associate Director for Operations, Assistant Director, and Chief Quality Officer. The Director, appointed in December 2020, had the longest tenure, and the Chief of Staff, who started in March 2026, was the newest leader. Other facility leaders referred to in this report may include managers, supervisors, and service chiefs who implement policies and maintain daily operations.

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.¹⁶ The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and

¹⁴ Clinics are in Baltimore, Cambridge, Fort Meade, Glen Burnie, Pocomoke City, and Rosedale.

¹⁵ A community living center is also referred to as a VA nursing home. “Geriatrics and Extended Care,” VA, last updated March 27, 2026, <https://www.va.gov/geriatrics/clc>. A domiciliary is “an active clinical rehabilitation and treatment program” for veterans. “Domiciliary Care for Homeless Veterans,” VA, last updated June 23, 2026, <https://department.va.gov/homeless/dchv>.

¹⁶ Valerie M. Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies,” *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

assess their level of trust in VA).¹⁷ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁸

System Shocks

During an interview, executive leaders stated that in April 2026, they noted a decrease in the facility's Centers for Medicare & Medicaid Services quality rating from three to two stars and described this as a system shock.¹⁹ The Director expressed a belief that because executive leaders focused on some lower performing metrics, they missed declines in others, which lowered the overall rating. Executive leaders further explained that before the rating declined, service leaders focused on individual quality indicators needing improvement rather than evaluating the facility's overall performance, which they believed limited their awareness of broader changes that contributed to the reduced quality.

In response to the lowered rating, executive leaders planned a unified approach to review all quality indicators weekly, hold executive and service leaders accountable for underperforming metrics, and integrate these reviews into the facility's committee structure. Leaders stated their efforts are intended to improve communication and ensure earlier identification of performance issues.

Executive leaders also identified the January 2025 requirement for employees to return to in-person work as a system shock.²⁰ At the time of the OIG inspection in May 2026, leaders reported that over 800 employees had returned to the office. They explained many employees had worked remotely for extended periods, and the return created challenges with workspace availability and parking. A community care employee said their assigned duty location is the Perry Point VA Medical Center, which is a long commute for those who live closer to the Baltimore area, and may affect the facility's ability to recruit. The leaders said they addressed these issues by modifying workspaces, relocating employees between facility sites, and clearing equipment from employee parking spaces.

¹⁷ "Veteran Trust in VA," VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁸ 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.

¹⁹ The Centers for Medicare & Medicaid Services Quality Star Rating system summarizes hospital performance across key quality domains into one to five stars using data from past reporting periods. Yale New Haven Health Services Corporation/Center for Outcomes Research & Evaluation, *CMS Overall Hospital Quality Star Rating Comprehensive Methodology Report (v5.1)*, April 2026.

²⁰ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

Employee Experiences

Respondents to the OIG questionnaire stated that executive leaders' communication was generally clear but infrequent or not useful.²¹ Many respondents also reported that the facility's culture was not moving in the right direction, but they felt comfortable suggesting actions to improve their work environment (see figure 2). Executive leaders reported using monthly all-employee town halls, work area visits, and daily tiered huddles (meetings between multiple levels of employees) to increase visibility, hear concerns directly, and follow up on issues.²²

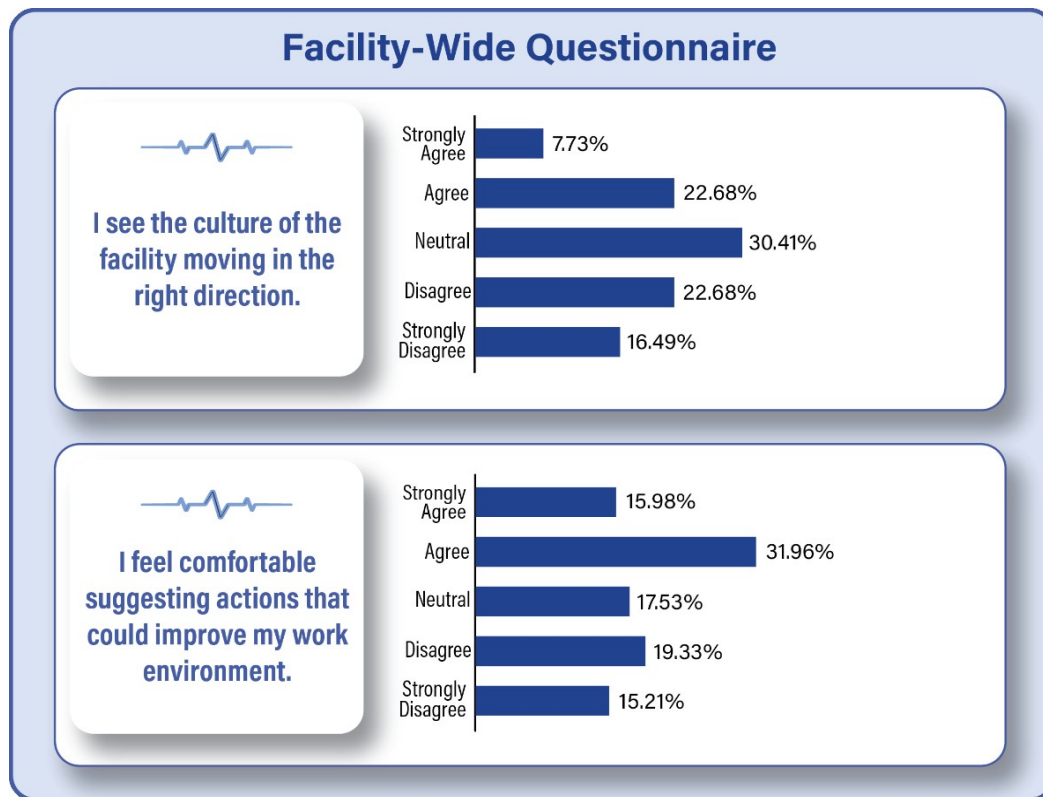


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

During an OIG interview, the leaders stated that siloed work and inconsistent follow-through negatively affected organizational culture, which led them to adopt an approach that strengthens communication and accountability. The Director recognized the need for enhanced communications and planned to send a monthly email to all employees, standardize all-employee messages, and provide more consistent town hall content across the facility's sites to promote a

²¹ The facility had 3,693 employees at the time of the questionnaire, which had a response rate of approximately 10.5 percent.

²² Kirthik Adapa et al., "The Effect of a System-Level Tiered Huddle System on Reporting Patient Safety Events: An Interrupted Time Series Analysis," *The Joint Commission Journal on Quality and Patient Safety* 48, no. 12 (2022): 642–52, <https://doi.org/10.1016/j.jcjq.2022.08.005>.

positive culture shift. The Director will also attend some service-level huddles to observe how leaders and employees share information and identify areas for improvement.

Many OIG questionnaire respondents reported that stress and burnout made them consider leaving the facility. Executive leaders said employees told them these problems resulted from administrative requirements, increased workload, and staffing concerns. In response, executive leaders stated they reduced administrative work by shortening meetings, removing duplicative reporting, and implementing artificial intelligence tools to make it faster for providers to document patient care. At the time of the OIG inspection in May 2026, executive leaders explained they were hiring in areas where employees identified staffing and workload concerns, such as the community care service. They also reported plans to expand a successful nursing check-in program that requires supervisors to meet with new employees at set intervals and then annually to identify workload strain, staffing issues, and early burnout.

Additionally, to better understand employee experience and engagement, leaders began developing an all-employee questionnaire for deployment by August 2026. The executive leaders stated they plan to use the results to gauge whether leaders' efforts address employee concerns such as overall satisfaction, communication, and workload. The Chief Quality Officer described several facility-wide initiatives to promote positive experiences, including employee appreciation activities, flexible work schedules, and monthly forums for employees to discuss safety issues and process improvements. Service leaders also reported formal recognition programs and career development opportunities.

Veteran Experiences

As shown in figure 3, the facility's VSignals trust scores were similar to VHA averages in the first two quarters of FY 2026, which indicates veterans' general trust in the facility's outpatient services. Patient advocates' responses to an OIG questionnaire showed that veterans' main concerns were unanswered phones; lack of return calls; and barriers to scheduling appointments, especially in the facility's community care service.

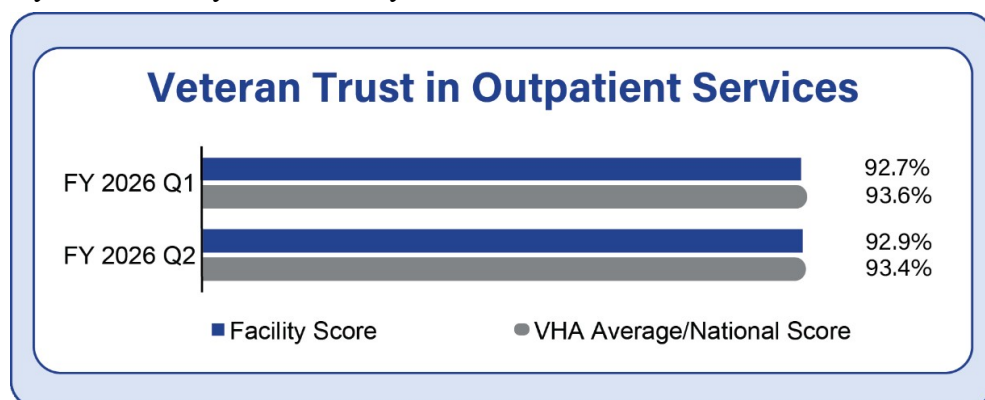


Figure 3. Veteran trust in outpatient services.
Source: VSignals data.

Executive leaders stated that general phone issues stemmed from high call volumes and misrouted extensions. In community care, the leaders said employees who schedule appointments also answered phones, which limited the amount of time they had to complete both tasks. Executive leaders also reported scheduling delays in specialty care clinics because there were not enough available appointment slots, which increased wait times.

At the time of the OIG inspection in May 2026, executive leaders explained they promoted veterans' use of secure messaging, started a workgroup to fix phone extensions, and hired more administrative staff to answer phones and schedule appointments. Additionally, executive leaders said they started reviewing provider schedules to increase appointment availability about 18 months prior to the inspection, and they recently created more appointments by shortening some to 30 minutes when clinically appropriate.

During OIG interviews, the team found that ineffective oversight of the patient advocacy program by executive leaders resulted in outdated rosters of service-level advocates and insufficient training on advocate responsibilities, leading to a significant number of patient complaints remaining unresolved. The OIG team also reviewed VHA facility data, which showed that about 31.5 percent of first-quarter FY 2026 patient complaints were overdue.²³ VHA Directive 1003.04, *VHA Patient Advocacy* requires timely resolution of all complaints and directs service-level advocates to resolve complaints at the point of service.²⁴ Executive leaders acknowledged that they needed to strengthen oversight of patient complaints, and facility patient advocate leaders explained that because employees did not have an accurate roster of service-level advocates, they could not route complaints correctly. This inaccuracy delayed them in resolving complaints, such as those about phone and scheduling problems. The consumer relations service chief reported that steps were being taken with executive and service-level leaders to address these issues.

The chief of consumer relations began actions in March 2026 to clarify service-level advocate roles and planned to update the rosters and train advocates. Executive leaders reported they started to review complaints weekly to hold service leaders accountable for closure timeliness in April 2026, which modestly reduced overdue complaints by 5 percent. The OIG did not make a recommendation because executive leaders and employees had already begun efforts to update rosters of service-level advocates and improve complaint resolution.

²³ VHA's Office of Patient Advocacy sets time frames for patient advocates to resolve complaints based on their priority and type. VHA Directive 1003.04, *VHA Patient Advocacy*, November 9, 2023.

²⁴ VHA Directive 1003.04.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.²⁵ 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.²⁶

General Inspection

The OIG team inspected clinical and nonclinical areas at the Baltimore, Perry Point, and Loch Raven medical centers. Inspectors found the main entrances to be well lit and clean. The Baltimore and Perry Point sites had information desks, and Baltimore and Loch Raven had contracted security guards posted at the main entrances. Each medical center had available parking, including accessible spaces for those with disabilities, and a shuttle that transported veterans between the facility's sites.

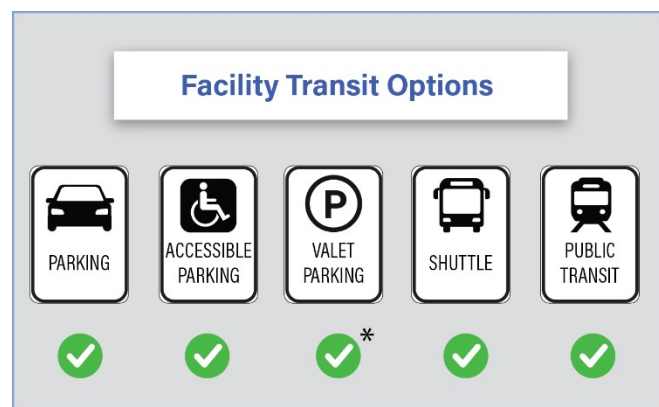


Figure 4. Transit options for arriving at the facility.

Source: OIG observations, interview with facility leaders, and facility-provided documents.

*The OIG identified valet services only at the Baltimore VA Medical Center.

However, the OIG team noted that navigational signs at all three medical centers were limited. Baltimore's main entrance lacked a visible directory or map, but printed material with maps was available. Perry Point had a directory, but it listed an urgent care clinic that was no longer open. Additionally, the OIG team reviewed patient advocate reports and learned that veterans complained about difficulties navigating the facility using posted signs, which the inspection team also experienced. According to VA's *Integrated Wayfinding & Recommended*

²⁵ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²⁶ VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

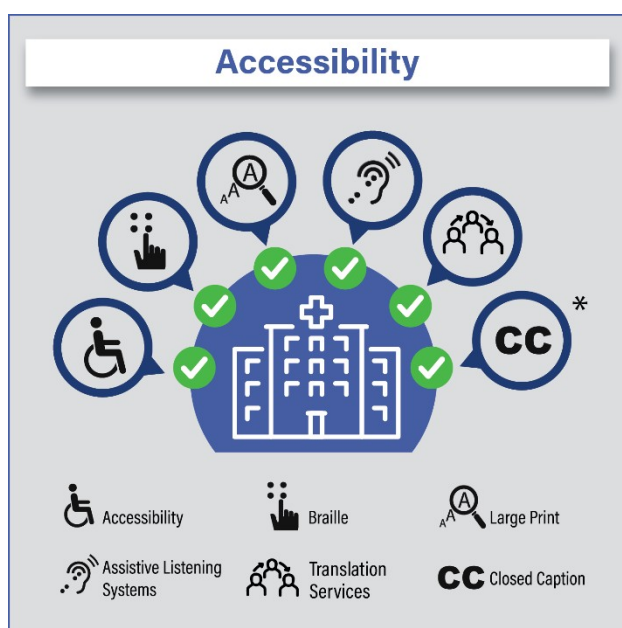


Figure 5. Accessibility tools available to veterans with impairments.

Source: OIG observations and facility staff questionnaire response.

*The OIG observed closed captions only at the Baltimore VA Medical Center.

with adequate natural or mechanical ventilation.²⁹ The OIG did not make a recommendation because staff reported an interim plan to move the liquid nitrogen tanks to a ventilated room until permanent storage with adequate air flow was available.

In a Baltimore intensive care unit, the OIG team observed a medication storage room locked with a padlock. The unit nurse manager told inspectors that the door's keypad was broken. Although unit staff requested repairs in 2024, the keypad was never fixed, so staff unlocked the padlock with a key stored at a desk in a common area. The OIG team was concerned that unlicensed staff could access the key and medications in the storage room. VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, states that medications must be stored in a secure manner with access limited to authorized staff (those who are licensed, trained, or designated by facility

Technologies, facilities should provide tools to help veterans reach their destinations.²⁷ During the inspection, the OIG team shared these observations with facility leaders, who were open to making changes and reported a plan to budget for navigation improvements in FY 2027.

At the Baltimore medical center, inspectors observed two liquid nitrogen storage tanks located in a small storage room with no visible ventilation vents. Liquid nitrogen converts to an odorless gas at room temperature and, when released into confined spaces, can rapidly displace oxygen and cause suffocation.²⁸ The team was concerned that staff who use the liquid nitrogen tanks in the storage room may be at risk of injury or death. According to the National Fire Protection Association's *NFPA 55 Compressed Gases and Cryogenic Fluids Code*, liquid nitrogen must be stored in a room

²⁷ VA, *Integrated Wayfinding & Recommended Technologies*.

²⁸ Occupational Safety and Health Standards, 29 C.F.R. § 1910.1200 (2024).

²⁹ "The Public Buildings Amendment Act (PL 100-678) requires all federal agencies to follow the latest editions of nationally recognized fire and life safety codes... VA has adopted the National Fire Codes (NFC) published by the National Fire Protection Association (NFPA), which establish a minimum acceptable level of life safety and property protection." VA, *Fire Protection Design Manual Ninth Edition*, November 1, 2023. The National Fire Protection Association, *NFPA 55 Compressed Gases and Cryogenic Fluids Code*, 2023 ed., 6.17, July 6, 2022.

policy to dispense, handle, or dispose of medications).³⁰ Inadequate medication security can increase the risk of drug diversion (unauthorized use or removal of medication from its intended recipient), tampering, or contamination. The OIG did not make a recommendation because the chief of the Facilities and Engineering Service reported a plan to install a digital keypad on the door the week after the May 2026 inspection. Following the inspection, the OIG confirmed in August 2026 that facility staff installed the digital keypad and the medication room was secured.

Further, at the Baltimore medical center, the OIG found a pull cord (call devices to signal for help) in a bathroom that was not accessible from the ground. In addition, at the community living center located at the Perry Point medical center, the OIG found patient shower rooms that either lacked a pull cord entirely or had one that was too short to be accessible. Pull cords enable patients to request immediate assistance after an event such as a fall. When call devices like pull cords are missing or inaccessible, patients may be unable to summon help during an urgent event, which may delay clinical staff response. The National Fire Protection Association's *NFPA 99 Health Care Facilities Code* requires bathrooms to have accessible and functional call devices that patients can reach when lying on the ground.³¹

Recommendation 1

The Associate Director requires bathroom and shower emergency pull cords to be present, accessible, and functional, in accordance with the National Fire Protection Association's *NFPA 99 Health Care Facilities Code*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The Chief Quality Officer (CQO) evaluated the identified non-compliance and conducted a thorough analysis of contributing factors. In collaboration with the Associate Director of Operations and the Associate Director for Patient Care Services, the CQO developed and implemented a standardized process to monitor the inspection and maintenance of emergency pull cords in patient-area bathrooms. The facility has achieved a compliance benchmark of 95% or greater for four consecutive months, which has been reported to the Executive

³⁰ VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

³¹ The National Fire Protection Association, *NFPA 99 Health Care Facilities Code*, 2024 ed., 7.3.3.1.2.5 and 7.3.3.1.6(3), September 14, 2023.

Leadership Team. Ongoing monitoring will continue to ensure continued compliance, with prompt identification and resolution of any variances.

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.



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(1), *Communicating Test Results to Providers and Patients* requires staff to develop a policy for communicating test results and service-level workflows that identify staff members' roles in the process.³² The OIG found the facility had a policy for the communication of test results. However, the facility had workflows for only some of the services that send or receive test results. Service-level workflows are important because timely communication of test results can help prevent delays in care and ensure veterans receive prompt follow-up and appropriate treatment. During the OIG inspection in May 2026, the Chief of Staff recognized this gap and reported that leaders planned to develop workflows for all services that required them.

Recommendation 2

The Chief of Staff develops written workflows for each service consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

³² VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

Director Comments

The Chief of Staff reviewed the identified non-compliance and conducted an analysis to determine contributing factors. In collaboration with the relevant service chiefs, the Chief of Staff developed and implemented service-specific communication workflows to ensure timely and appropriate communication of test results. Each service has adopted and implemented these workflows. The Chief of Staff has reported the completion of corrective actions and the implementation of these service-specific workflows to the Executive Leadership Team.

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.

The OIG team's review of the facility's metrics for the communication of test results showed improvement from FY 2024 through the first two quarters of FY 2026.³³ At the time of the May 2026 inspection, the facility's metrics (90.48 percent) were above VHA national averages (87.51 percent). The outcome measures program lead attributed the improved performance to their working directly with providers to ensure patients are notified about test results that had not been communicated within the required time frames.³⁴ The Chief of Staff and the Associate Director for Patient Care Services/Chief Nurse Executive told the OIG during interviews that they receive and review monthly emails about those outliers.

Action Plans and Process Improvements

Staff completed actions to resolve all recommendations from the 2023 OIG healthcare inspection by March 2025.³⁵ At the time of the May 2026 inspection, the facility had two open (unimplemented) recommendations from a 2025 OIG healthcare inspection related to community care consults; however, by June 2026, one of those recommendations had been resolved.³⁶ The

³³ Communication of Test Results (CTR) 24 is a metric that identifies "the percent of outpatient tests with Abnormal results" requiring action that staff communicate to patients within seven days "from the time the test result is available." VHA does not have a set target for CTR measures but indicates "higher is better" for scoring purposes. "Electronic Technical Manual (eTM) Measure Specification," VHA Office of Quality and Patient Safety Performance Measurement, accessed June 30, 2026, <http://pm.rtp.med.va.gov>. (This website is not publicly accessible.)

³⁴ VHA mandates "test results requiring action must be communicated to patients within 7 calendar days from the date on which the results are available to the Department of Veterans Affairs (VA) medical facility ordering provider or designee and 14 days for those that do not require any action." VHA Directive 1088(1).

³⁵ VA OIG, [Comprehensive Healthcare Inspection of the VA Maryland Health Care System in Baltimore](#), Report No. 23-00159-160, May 2, 2024.

³⁶ VA OIG, [Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore](#), Report No. 24-02031-171, July 16, 2025.

OIG team reviewed four months of FY 2026 Executive Quality and Patient Safety Committee minutes and found that staff had developed and were implementing action plans to address the open recommendation regarding implementation of a care in the community consult management process to focus on consult completion.

The Chief of Staff told the OIG that the facility had a high volume of view alerts (notifications to providers in electronic health records, often for urgent clinical information) in FY 2025, which created a backlog of unresolved alerts. Effective use of view alerts helps to ensure providers act promptly on clinical information, which reduces the risk of missed or delayed care. A supervisory program analyst reported a reduction in unresolved view alerts in FY 2026, and credited process changes made by the facility's view alerts workgroup in September 2025. Further, the analyst stated that clinical informatics staff (who manage and support health information technology in electronic health records) enhanced processes for tracking view-alert errors (such as not sending alerts to covering providers) and collaborated with service chiefs to resolve them.

Additionally, the OIG team learned from quality and patient safety staff about a process improvement project that had a positive impact on patient care. Staff explained that video monitoring of patients at risk of falling, launched in April 2025, reduced falls by enabling more than 12,000 real-time interventions; it also prevented falls resulting in fractures in the Baltimore medical center's acute care units for a full year. Staff told the OIG that, based on this success, they plan to expand the program to the facility's two community living centers.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.³⁷ The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The OIG team reviewed a facility document that showed 61 teams provided primary care services at the facility. At the time of the May 2026 inspection, leaders reported vacancies across all primary care positions, including providers, registered nurses, licensed practical nurses, and

³⁷ "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.

medical support assistants. The Associate Director for Patient Care Services/Chief Nurse Executive reported difficulty filling licensed practical nurse positions due to a national shortage. The associate director also stated the facility used a nurse recruiter and increased nursing salaries in FY 2025. Additionally, the patient centered management module coordinator told the OIG that it was hard to fill on-site medical support assistant positions because applicants are seeking remote work.

The OIG team reviewed VHA data from April 27, 2026, and found the average primary care panel size (the number of patients assigned to a care team) was 94 percent of the expected level outlined in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.³⁸ However, about one third of the primary care teams operated at more than 100 percent capacity, indicating workload imbalances and possible inefficiencies in clinic staffing. VHA Directive 1406(3) requires staff to use the patient centered management module to track primary care teams, staffing, and patient panels, and assigns responsibility to the chief of staff (or a delegate) to review efficiency, capacity, and staffing data. When asked during the May 2026 site visit how often they reviewed panel sizes or what process they used to manage efficiency, the primary care leaders and the patient centered management module coordinator were not able to describe a defined or routine process, noting only that they typically adjusted panels when a provider left.

Recommendation 3

The Chief of Staff develops and implements a standardized process to routinely assess panel size and efficiency, as required by Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Staff evaluated the identified non-compliance and determined the contributing factors. In response, a standardized process was developed and implemented for routinely assessing panel size and panel efficiency. A PCMM Coordinator has been onboarded, filling the previously identified vacancy. The standardized process is now in place and will be utilized moving forward to ensure ongoing monitoring of panel size and efficiency. Panel sizes

³⁸ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

have been balanced. The Chief of Staff will maintain oversight of this process to sustain compliance, which is reported to the Executive Council of the Medical Staff.

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.

The Code of Federal Regulations, title 38, section 17.4040 (community care access) states that patients may be referred to community providers if wait times are longer than 20 days.³⁹ Facility data for FY 2026 through April showed average primary care appointment wait times were close to 20 days for new patients and 6 days for established patients. Primary care leaders attributed the favorable wait times to extended clinic hours, expanded nurse appointment availability, and the use of temporary providers to cover short-term staffing needs.

Community Care Staffing and Access to Care

At the time of the OIG site visit in May 2026, the care in the community associate chief of staff reported vacancies among advanced medical support assistants. The associate chief also stated that hiring for the positions was in progress. Additionally, the leaders noted that the referral volume had grown over the past three years, while staffing levels had not increased to meet the demand. The associate chief reported exploring ways to expand and diversify staffing, including the potential recruitment of nurse practitioners, physician assistants, and program support staff, based on discussions with the Veterans Integrated Service Network (VISN) and staffing roles used in other facilities.⁴⁰

The OIG team examined facility data through June 2026 and found that dental care, mental health, and podiatry were the top specialties staff referred to the community based on wait time eligibility. For the top three specialties, community care staff averaged 49 days to schedule veterans' appointments, which exceeded the 7-day scheduling benchmark required by VHA's

³⁹ 38 C.F.R. § 17.4040 (2025).

⁴⁰ VA administers healthcare services through a nationwide network of regional systems referred to as 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 VHA. 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>.

*Consult Timeliness Standard Operating Procedure.*⁴¹ The acting associate chief of staff for the Ambulatory and Emergency Care Clinical Center reported that mental health providers were using only about 65 percent of their appointment slots, which contributed to a high volume of community care referrals. During an OIG interview, executive leaders reported efforts to maximize mental health provider efficiency through annual reviews of provider clinic grids (appointment availability), active monitoring of unscheduled appointments, and strengthened scheduling practices. However, the OIG inspection team was concerned that care was being referred to the community when facility providers had unused capacity and referred this issue to the OIG’s hotline team for further review.

The care in the community associate chief of staff said they met regularly with dental leaders to address referral volume and implemented a project to reduce unscheduled referrals older than 180 days. However, aside from those actions, the community care leader did not report a process or plan to meet the seven-day scheduling requirement.

Recommendation 4

The Director develops and implements a process to meet the seven-day scheduling requirement in Veterans Health Administration’s *Consult Timeliness Standard Operating Procedure*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The Director evaluated the identified non-compliance and determined the contributing factors impacting the facility’s lack of process to meet the seven-day consult scheduling requirement. The facility notes that OIG previously recommended this requirement be assessed for feasibility in the “Care in the Community Deficiencies and Ineffective VISN Oversight at the VA Maryland Health Care System in Baltimore” report, 24-02031-171. The facility implemented a Tiered Metrics and Performance Work and Briefing process in May 2026, which was converted to the Organizational Performance Improvement Committee in September 2026. Care in the Community participates in designated work groups, leads targeted performance improvement initiatives, and provides routine reports on progress, barriers, and resource needs.

⁴¹ VHA Office of Integrated Veteran Care, “Consult Timeliness Standard Operating Procedure (SOP),” updated October 2, 2025.

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.



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.

Security at the Baltimore VA Clinic

An OIG inspector toured the facility's homeless programs at the Baltimore VA Clinic, located in a densely populated downtown area. This clinic includes the facility homeless program's community resource and referral center (a unique walk-in program designed to assist veterans experiencing homelessness) which is staffed by social workers, a psychiatric nurse practitioner, and a psychologist.⁴² Facility documents showed that in April 2026, clinic staff assisted 91 walk-in veterans and provided 429 lunches and 119 food pantry bags. The clinic also had a laundry room, showers, clothing resources, and telephones for veterans to use.

An OIG inspector observed warnings about a weapons ban and weapon searches posted on the building's front-entry doors. Despite the posted warnings, staff reported security concerns to the inspector, including nonfunctional panic alarms and a rarely used metal detector.

Program staff described a March 2026 incident at the clinic when a veteran entered the building wearing a large, sheathed knife that went unnoticed by contract security and VA police. While meeting with walk-in clinic staff in a private office, the veteran unsheathed the knife (not in an overtly threatening manner), and on-site VA police escorted them out of the building. The staff member later reported to their supervisor that the veteran acknowledged knowing the knife was prohibited but carried it anyway.

The chief of police services explained that the clinic's metal detector requires two officers to operate and is used only intermittently due to staffing limitations. The chief also stated that clinics are not required to have panic alarms; the current nonfunctional alarm system cannot be

⁴² The Baltimore VA Clinic (annex), located three blocks from the facility, houses administrative, clinical, research, outpatient, and veteran resource programs. VA Maryland Health Care System, *Baltimore VA Annex Visitor Guide*, accessed May 22, 2026, https://www.va.gov/files/2022-03/bal_annex_VG_0.pdf.

repaired or upgraded due to its age; and a replacement is not cost-effective because a new Baltimore clinic, with a full police station, is expected to open in 2030.

Further, the chief of police services said the clinic has contracted security on-site as well as a full-time VA police officer, although the officer is sometimes off-site to respond to higher priority needs. The chief also noted that VA police patrol homeless program areas and escort veterans with patient record flags (notices in their electronic health record as a behavioral safety risk to other patients or staff) to their appointments. The chief added that staff are required to call 911 during emergencies, and the clinic is monitored by cameras around the clock.

The OIG communicated clinic security concerns to executive leaders during the exit briefing on May 14, 2026. VA Handbook 0730/4, *Security and Law Enforcement*, outlines the annual physical security survey requirements of spaces within VA’s jurisdiction to ensure effective risk identification, planning, and resource allocation.⁴³ Accordingly, the OIG issued a recommendation.

Recommendation 5

The Director considers a security assessment to identify risks at the Baltimore VA Clinic, in accordance with VA Handbook 0730/4, *Security and Law Enforcement*.

☒ Concur

☐ Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Police Services evaluated the identified security risks and completed a comprehensive security assessment of the Baltimore VA Clinic (Annex) on May 12, 2026, in accordance with VA Handbook 0730, *Security and Law Enforcement*. An action plan was created.

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.

⁴³ VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

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.⁴⁴

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).⁴⁵ HCHV2 measures the percentage of veterans who are discharged from the contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits)."⁴⁶

Performance and Improvement Highlights

- The facility program missed the target for exits to permanent housing (HCHV1) for FY 2025 but met it in the first two quarters of FY 2026. The program coordinator reported that staff met the quarterly targets for FY 2026 by promptly linking veterans to needed treatment and meeting monthly with them to keep housing progress on track.
- The program met the target for negative exits (HCHV2) for FY 2025 and in the first two quarters of FY 2026. The program coordinator attributed this success to effective collaboration with HUD-VASH staff and community partners that secured permanent housing for veterans.

⁴⁴ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁵ VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between four and six months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

⁴⁶ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

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.”⁴⁷ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.⁴⁸

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).⁴⁹

Performance and Improvement Highlights

- The facility program did not meet the voucher use (HMLS3) target for FY 2025 but did meet it in the first two quarters of FY 2026. The assistant chief of social work community integration services reported that program staff participated in two community events to reach veterans experiencing homelessness in February and April 2026, which helped them meet the FY 2026 quarterly targets.
- The program met the employment (VASH3) target for FY 2025 and the first two quarters of FY 2026. The assistant chief stated that the program has three employment specialists and two vocational staff to support veterans with employment needs.
- Facility documents showed that the facility’s Perry Point site included project-based housing units (where the housing voucher stays with the unit, not the veteran). A nonprofit organization operates the units under a lease agreement with VA. However, the assistant chief described safety concerns related to drug use at the site. In response, program nurses provided naloxone (a medication to reverse an opioid overdose) training to veteran residents of the housing site, and in February 2026, VA police held a town hall with stakeholders to reinforce program rules. Facility documents showed executive leaders implemented additional safety actions, including a Perry Point police instant messaging channel, joint VA police

⁴⁷ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁸ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁹ 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*.

and mental health training for staff, and expanded VA police canine drug sweeps on-site.

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.⁵⁰ 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).⁵¹

Performance and Improvement Highlights

- The facility program had four social workers who covered six treatment courts (a supervised court that offers treatment and support to veterans) and provided services across 19 jails and 13 prisons.⁵²
- The program did not meet the enrollment (VJP1) target for FY 2025 or the first quarter of FY 2026 but did meet it in the second quarter. The program coordinator reported that in FY 2025, staff had difficulty contacting referred transient veterans and were unable to meet with veterans in jail due to intermittent security restrictions (jail lockdowns).
- To address these challenges, the coordinator stated that staff asked community partners to give contact information for the Veterans Justice Program directly to veterans, and they encouraged jails to use virtual technology for meetings when restrictions apply.
- Facility documents showed that the local veterans treatment courts had a 77 percent successful graduation rate in FY 2025. A program social worker noted that in one treatment court, veterans can complete community service hours by training service dogs, which service members later adopt as support animals.

⁵⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁵¹ 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*.

⁵² VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the VA Maryland Health Care System, the OIG conducted an inspection across five domains. The OIG made five recommendations related to emergency call devices, service-level workflows, primary care panel management, community care appointment scheduling, and security at the Baltimore VA Clinic. Facility leaders have implemented corrective actions, which resulted in the OIG closing all recommendations. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.⁵³ 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 physically inspected various areas of the medical facility from May 11 through 14, 2026. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. 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.⁵⁴ 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*.⁵⁵

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁵⁶ 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.

⁵³ The accreditation reports covered the time frame of October 1, 2023, through September 30, 2024—the most recent available at the time of the inspection.

⁵⁴ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁵⁵ 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.

⁵⁶ 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 1978.⁵⁷ 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.

⁵⁷ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 2, 2026

From: Director, VA North Atlantic Health Network (10N1)

Subj: Healthcare Facility Inspection of the VA Maryland Health Care System in Baltimore

To: Director, Office of Healthcare Inspections (54HF03)
Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed and concur with the findings and recommendations concerning the Office of Inspector General's draft report entitled Healthcare Facility Inspection of the VA Maryland Health Care System in Baltimore.
2. I have reviewed the response provided by the Medical Center Director, VA Maryland Health Care System. I concur with the corrective actions and request to close recommendations numbered: one, two, three, four, and five.
3. Thank you for this opportunity to focus on continuous performance improvement. Should you require any additional information please contact the VISN 1 Network Office.

(Original signed by:)

Joseph Scotchlas
Interim VISN 1 Director
for
Ryan S. Lilly, MPA
VISN 1 Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 14, 2026

From: Director, VA Maryland Health Care System (512)

Subj: Healthcare Facility Inspection of the VA Maryland Health Care System in Baltimore

To: Director, VA North Atlantic Health Network (10N1)

1. The VA Maryland Health Care System (VAMHCS) is submitting a response to the five recommendations associated with the OIG Report: Healthcare Facility Inspection of the VA Maryland Health Care System in Baltimore.
2. VAMHCS is requesting closure of Recommendations #1, 2 3, 4 and 5.
3. Please contact me if you should have any further questions.

(Original signed by:)

Christopher Buser
Deputy Medical Center Director
for
Jonathan R. Eckman, P.E.
Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Director, VA Maryland Health Care System (512)

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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.