



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Phoenix Health Care System in Arizona

**Healthcare Facility
Inspection**

26-00041-05

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 VA Phoenix Health Care System (the facility) from January 12 through 15, 2026. Additionally, the OIG team contacted facility staff in July and August 2026 to obtain updated information. The facility is rated as *highest complexity* and in fiscal year 2025, served approximately 123,700 veterans.¹ The inspection team examined aspects of care delivery and patient safety within the facility using five domains.²

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The 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. Inspectors found that the facility lacked service-level workflows that outline staff roles in the process to communicate test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.³ The OIG recommended corrective actions for this finding.
- **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.

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] 22) Carl T. Hayden 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 Chief of Staff and Associate Director for Patient Care Services develop written service-level workflows that outline staff members' roles in the process to communicate test results to patients, 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 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 The OIG will follow up on the planned actions until they are completed.



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⁵ 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

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Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.⁶ VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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



Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.⁷



Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.⁸



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



Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.



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

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

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

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

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

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

The VA Phoenix Health Care System (the facility) serves veterans across five counties in central Arizona. It includes the Carl T. Hayden VA Medical Center and community-based outpatient clinics in Phoenix, Gilbert, Mesa, Scottsdale, Payson, Show Low, Globe, and Surprise, Arizona. In fiscal year (FY) 2025, the facility’s medical care budget was over \$1.7 billion. It had 166 hospital, 24 domiciliary, and 50 community living center beds and provided care to approximately 123,700 veterans.¹¹



Figure 1. Facility photo.

Source: “VA Phoenix Health Care,” VA, accessed January 29, 2026, <https://www.va.gov/phoenix-health-care>.

The OIG team inspected the facility from January 12 through 15, 2026, and contacted facility staff in July and August 2026 for updates. The executive leaders referred to throughout this report include the interim Medical Center Director (Director), Deputy Director, Chief of Staff, Deputy Chief of Staff, interim Associate Director for Resources, Associate Director for Operations, Associate Director for Patient Care Services, and Deputy Associate Director for Patient Care Services.



CULTURE

The OIG team examined the facility’s culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization’s daily operations), and both employees’ and veterans’ experiences.¹² The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).¹³ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁴

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/dchv>. A community living center is also referred to as a VA nursing home. “Geriatrics and Extended Care,” VA, last updated March 27, 2026, https://www.va.gov/VA_CLC.

¹² Valerie M. Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies,” *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

¹³ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁴ Patient advocates are employees who receive feedback from veterans and help resolve their concerns. “Patient Advocate,” VA, last updated May 9, 2022, <https://www.va.gov/patientadvocate>. For more information on the OIG’s data collection methods, see appendix A.

System Shocks

Executive leaders identified recurring infrastructure failures due to the medical center's age as a system shock, citing outdated plumbing as well as problems with the roof; electrical system; and heating, ventilation, and air-conditioning. Leaders reported seven water-related outages at the medical center in 2025, including a major leak in January that caused a water shutdown and disrupted operations for several hours. In response to the leak, employees rescheduled 115 patient appointments, with no reported adverse patient safety events. At the time of the inspection in January 2026, facility management service employees had finished most repairs and had plans to fix additional leaks in the community living center and outpatient dental clinic. The OIG followed up in July 2026; the facility operations supervisor reported that the community living center's leak had been fixed and repairs to the dental clinic were expected to be completed in September 2026.

Facility staff also identified key leader turnover as a major system shock. The executive leadership team had multiple positions filled by interim staff since 2024. The interim Director and interim Associate Director for Resources had served since April 2025, and other executives joined between November 2024 and July 2025. Executive leaders acknowledged that turnover affected employees' trust and stability, so they implemented the following strategies in response:

- To increase transparency and communication, leaders visited work areas during day and night shifts to interact with employees. If employees expressed concerns, leaders held monthly sessions to answer questions and explain any organizational changes.
- To build strong processes for continuity, leaders standardized emergency and operational procedures to ensure they remain consistent regardless of leader changes, created shared governance councils to involve employees in decision-making, and replaced multiple one-on-one discussions with collaborative meetings between executive and clinical leaders.
- To enhance employee communication and engagement, leaders gathered feedback through an employee engagement survey and implemented a weekly newsletter to share information.

Employee Experiences

Most respondents to the OIG questionnaire reported feeling comfortable raising safety concerns. About 39 percent agreed the facility’s culture is improving, and 54 percent felt comfortable suggesting actions to improve their work environment, as shown in figure 2. However, 39 percent cited stress and burnout as the main barrier to doing their job.

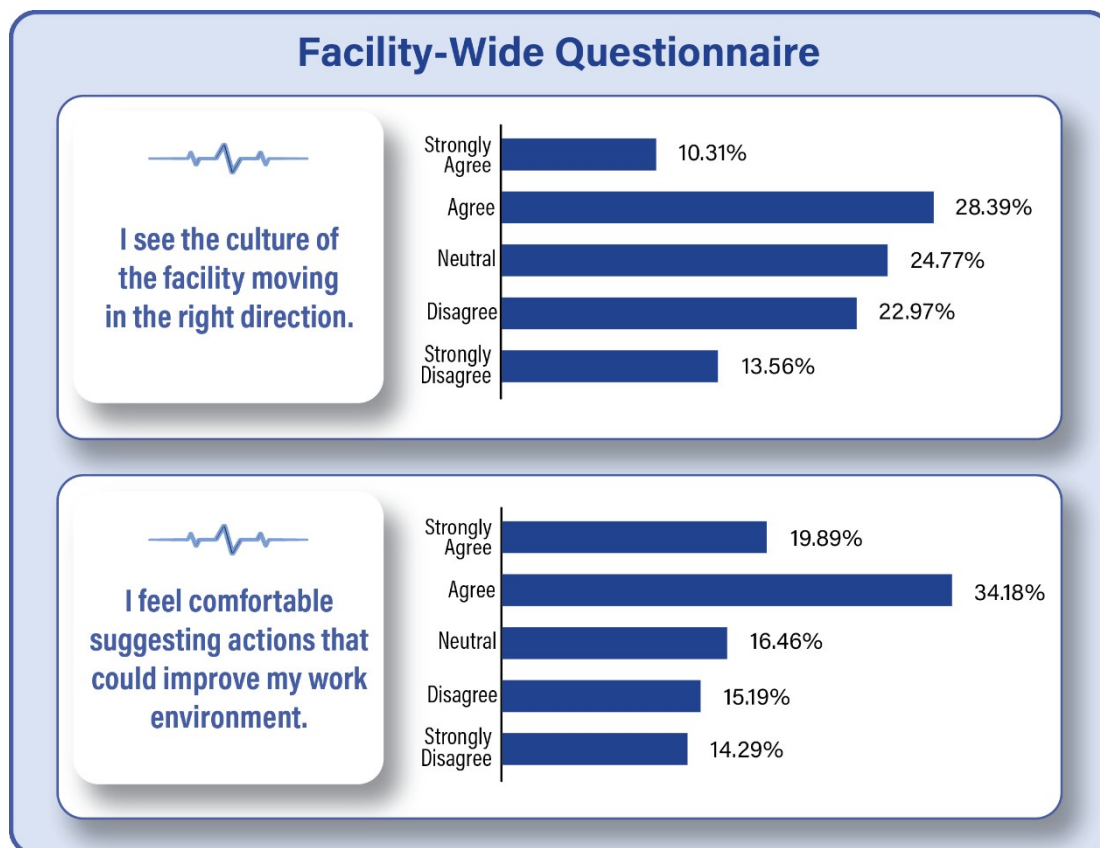


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

To improve employees’ experiences, executive leaders took the following actions:

- To create a psychologically safe culture, leaders implemented a civility campaign to train work groups in conflict management.¹⁵ They also launched a *Pathway to Excellence* (a national designation for organizations that support healthy nursing environments) initiative and wear *Pathway* shirts on Wednesdays to show it is an organizational priority.

¹⁵ “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>.

- To promote well-being and reduce burnout, facility leaders offered employees mindfulness, stress management, and fitness activities, as well as chaplain-led support sessions and peer connection forums.

Veteran Experiences

The interim Director highlighted the facility's two Veteran Resource Centers as a key initiative to enhance veterans' experiences. The centers' patient advocates and social workers work together in centralized locations to help veterans schedule appointments, request medical records, and navigate benefits and billing questions. In FY 2025, the main Veteran Resource Center had over 18,000 visits from veterans, and the second location, in a nearby community-based outpatient clinic, had more than 8,000. Leaders said this approach reduces delays that frustrate veterans.

The interim Associate Director for Operations acknowledged that due to the vacant veterans experience officer position, the facility currently lacks a Veteran Experience Committee. Executive leaders recognized the committee as an important mechanism for capturing and addressing veterans' concerns and plan to reinstate it once the new staff lead for the High Reliability Office starts.

Patient advocates identified insufficient provider communications, delays in appointment scheduling, lack of available durable medical equipment, and challenges with the phone system in the call center as common veteran complaints. At the time of the inspection in January 2026, leaders said a workgroup was developing a process to improve provider communication. They also reported that staff responsible for durable medical equipment had revised their process to ensure equipment was available when needed, and leaders hired additional call center staff, which helped reduce dropped calls.

Further, a patient advocate reported that services address individual complaints but do not resolve the recurring patterns, which results in similar concerns from other veterans. Leaders acknowledged the need to identify and proactively resolve issues by using tools like VSignals and the Patient Advocate Tracking System (an electronic system the advocates use to document veterans' concerns) to strengthen their data review and trend analysis.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.¹⁶ 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.¹⁷

General Inspection

The OIG team inspected the medical center and the Phoenix 32nd Street VA Clinic, which offers primary care services. Each location had clear directional signs, adequate parking with accessible spaces for those with disabilities, and nearby public bus stops. The medical center also offered shuttle services.

Both main entrances included covered areas for passenger loading and unloading, power-assisted sliding doors, and wheelchairs. Entrances were bright and welcoming, with natural light. Maps were available on request.

Volunteers greeted veterans, answered questions, and assisted with navigation at both locations. The volunteers said they communicate with hearing-impaired veterans by using written instructions, and escort those with visual impairments to appointments. Facility program leaders confirmed that staff have access to a telephone language line to communicate with veterans in different languages. The OIG team observed large print signs and braille on room placards and outside the

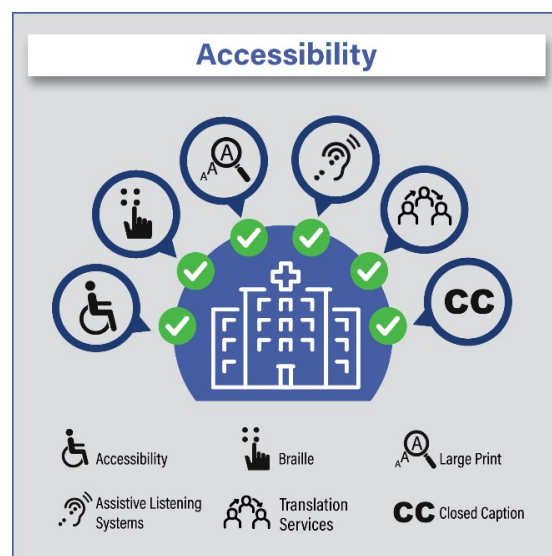


Figure 3. Accessibility tools available to veterans with impairments.

Source: Inspector observations and facility liaison questionnaire responses.

¹⁶ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

¹⁷ 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-edition, EC.02.06.01, July 1, 2025.

elevators at both sites. Additionally, all elevators were equipped with audio cues to improve accessibility.

The team inspected the medical surgical unit, intensive care unit, community living center, and emergency department at the medical center, and the primary care area at the Phoenix 32nd Street VA Clinic. These areas were generally clean and well-maintained, with no identified safety or privacy issues.



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

VA medical facilities were required to update local policies to comply with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.¹⁸ The OIG found that the facility's policy had not been updated since June 2021. However, during the site visit in January 2026, facility staff finalized the medical center policy and provided it to the OIG.¹⁹ The OIG reviewed the updated policy and found it did not contain or reference service-level workflows that identify all providers and staff who can communicate test results to patients as required by the VHA directive.²⁰

The chief of quality management explained that turnover among quality management staff, combined with reliance on a single individual for policy management, resulted in multiple policies being overdue. In August 2025, executive leaders formed a workgroup to implement an electronic tracking process to ensure future oversight and timely policy updates. Leaders acknowledged the process was still maturing but noted significant improvements in recent months, including increased policy publication volume, added administrative support, and the onboarding of an accreditation readiness manager to oversee the process.

¹⁸ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

¹⁹ Phoenix VA Health Care System Policy Memorandum 11-102, *Communicating Test Results to Providers and Patients*, June 10, 2021; Phoenix VA Health Care System Policy Memorandum 11-102, *Communicating Test Results to Providers and Patients*, January 13, 2026.

²⁰ VHA Directive 1088(1).

Recommendation 1

The Chief of Staff and Associate Director for Patient Care Services develop written service-level workflows that outline staff members' roles in the process to communicate test results to patients, in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

Target date for completion: December 31, 2026

Director Comments

The Phoenix VA Health Care System (PVAHCS) Chief of Staff, Associate Director of Patient Care Services, Deputy Chief of Staff and Deputy Associate Director of Patient Care Services reviewed VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* and PVAHCS Medical Center Policy (MCP) 11-102 *Communicating Test Results to Providers and Patients*. The MCP was updated with the link to a newly developed PVAHCS Communication of Test Results SharePoint that provides access to service level workflows

Service level workflows were reviewed by the leadership team and signed by both the Chief Nurse and the Chief Physician that oversees the clinical area for each workflow. These workflows were posted to the PVAHCS Communication of Test Results SharePoint. On September 28, 2026, MCP 11-102 *Communicating Test Results to Providers and Patients* was signed by the Medical Center Director and disseminated to all Service Chiefs, Medical Staff, Chief Nurses and Nurse Managers. The revised MCP is also published on the PVAHCS Policy SharePoint.

The PVAHCS System requests closure of this recommendation prior to publication.

OIG Comments

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

VHA Directive 1088(1) also requires each facility to monitor how test results are communicated to providers and patients. Quality management staff submit quarterly reports on abnormal test result communication to the Quality and Patient Safety Board, which includes the Chief of Staff and the Associate Director for Patient Care Services. The OIG reviewed the quality data on test result communications for FY 2025 and found the facility complied with the requirement to communicate test results that require action to patients within seven days.

Action Plans and Process Improvements

The patient safety manager reported the facility had completed all corrective actions for recommendations from oversight agencies in the three years prior to the January 2026 inspection. Quality management staff said they monitor action items from oversight agencies during committee meetings.

The patient safety manager explained that facility staff report safety concerns through the Joint Patient Safety Reporting system—a database used at VA facilities to report patient safety events, such as adverse events and close calls.²¹ The patient safety manager added that staff use a spreadsheet to track recurring patient safety events and monitor related process-improvement efforts. For example, the infusion clinic partnered with the pharmacy to enhance tracking for patients' upcoming infusion needs and ensured necessary medications and supplies were available.

However, the OIG identified trends related to delays in receiving imaging results from the National Teleradiology Program. The chief of radiology acknowledged the delays and reported no resulting patient harm. In response, the chief explained that the facility implemented a local contingency plan: if the teleradiology program cannot provide a result within four hours, the provider who ordered the test contacts the radiology department, and an on-call radiologist interprets the study.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.²² The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The facility delivers primary care through 101 teams at 10 outpatient clinics. As of August 2026, primary care continues to have significant staffing needs for providers and support staff. Recruitment is ongoing, with several positions filled or pending selection and multiple new hires

²¹ VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook, Version 6.0*, October 1, 2025.

²² "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.

expected to start in August and September 2026. Most remaining vacancies are still in the recruitment process.

Facility and primary care leaders said they reviewed vacancies weekly and used a recruiter to fill positions. They also noted that retirements affected staffing despite strong recruitment in 2025. The leaders added that they use designated staff and virtual providers from the Veterans Integrated Service Network's Clinical Resource Hub to cover for vacancies.²³ In addition, some administrative support staff shifted from specialty to primary care, and staff used automated systems and the call center more frequently to communicate with veterans and manage appointments.

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.²⁴ In quarter three of FY 2025, primary care appointment wait times averaged 20 days.

Staff also shared workflow challenges and office design improvements. They reported that patient self-scheduling improves access to care but can inadvertently disrupt clinic workflow because providers may not have the laboratory test results they need prior to the visit. In response, the chief nurse of ambulatory care explained that staff check for newly scheduled appointments at the beginning of each shift, use team huddles (short meetings) to communicate and plan for daily appointments, and enter any necessary requests for laboratory testing. Additionally, staff highlighted a new outpatient clinic design that minimizes patient movement and supports care coordination: the team's work area is in the center of the clinic, surrounded by exam rooms, and patients remain in one exam room while primary and specialty care staff move from room to room. A staff member explained that the room-based workflow works well for patients because it keeps them in one location and increases efficiency.

Community Care Staffing and Access to Care

Facility documents showed 81,134 community care consults in FY 2025, which was 15,385 more than the year before. Community care leaders attributed the increase to facility specialty care providers' retirements and difficulty recruiting mental health providers. The leaders reported

²³ Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Networks," last updated July 17, 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>. Clinical Resource Hubs "increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, <https://www.patientcare.va.gov/CRH>.

²⁴ 38 C.F.R §17.4040 (2025).

one registered nurse and six medical support assistant vacancies for the community care program; five positions were in the hiring process and two were pending recruitment. Leaders said they believed it was hard to hire because salaries were not competitive with other local facilities.

In FY 2025, community care staff scheduled appointments within an average of 14 days, twice as long as the 7-day standard in VHA's *Consult Timeliness Standard Operating Procedure*.²⁵ Staff said the delays occurred due to the high number of consults, limited community provider availability, and the multiple steps involved in coordinating complex patient care. Community care leaders and staff explained that community care providers need time to review and accept cases, and they believe the 7-day standard is unattainable. Despite these challenges, leaders stated the program has strong processes, effective team management, and dedicated staff.



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.²⁶

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

²⁵ VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," last updated October 2, 2025.

²⁶ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

residences for veterans with mental health or substance use conditions).²⁷ HCHV2 measures the percentage of veterans who are discharged from program’s contracted emergency residential services or low-demand safe haven beds due to a “violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits).”²⁸

Performance and Improvement Highlights

- The facility program met the permanent housing (HCHV1) target for FY 2025. The HCHV coordinator and outreach social worker explained that staff from the contracted emergency residential services and low-demand safe haven programs used behavior management plans (personalized strategies designed to support individuals in meeting their goals) to encourage veterans to pursue and maintain permanent housing.
- The facility program also met the negative exits (HCHV2) target for FY 2025. The coordinator stated the program has one contracted emergency residential program in the service area, which has 28 beds. The coordinator attributed success in meeting the measure to the residential services liaison, who provided case management to veterans living in the housing units.

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.”²⁹ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³⁰

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

²⁷ 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 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.

²⁸ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

²⁹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).³¹

Performance and Improvement Highlights

- The facility program achieved the voucher use (HMLS3) target for FY 2025. A HUD-VASH supervisor credited the program’s success to strong community partnerships, streamlined processes with public housing agencies, and available affordable housing.
- The facility program also met the employment (VASH3) target for FY 2025, although program staff said demographic characteristics and health challenges in the veteran population were barriers to consistent employment outcomes. To address these challenges, a supervisor said staff strengthened collaboration with the Compensated Work Therapy program, which led to increased opportunities for veterans to access employment support services.³²
- One of the program’s social workers, who is assigned to enrolled members of federally recognized Native American tribes, collaborated with the White Mountain Apache and San Carlos Apache housing agencies to strengthen interagency relationships, improve access to housing funds, and provide care that respects each tribe’s culture.

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.³³ 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).³⁴

³¹ 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*.

³² 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/cwt>.

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

³⁴ 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 program met the enrollment (VJP1) target for FY 2025. Facility program staff reported that new treatment courts in the service area increased referrals and enrollment in the program.³⁵ These courts were established in response to population growth, which expanded the number of individuals eligible for referrals.
- Staff conducted outreach to jails and courts in the local service area, and to prisons throughout the state.

Conclusion

To assist leaders in evaluating the quality of care at the VA Phoenix Health Care System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to service-level workflows. 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.

³⁵ "A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." 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.³⁶ 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. The OIG physically inspected various areas of the medical facility from January 12 through 15, 2026, and contacted facility staff in July and August 2026 to obtain updated information. During site visits, the OIG 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.³⁷ 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*.³⁸

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.³⁹ 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.

³⁶ The accreditation reports covered the time frame of October 1, 2022, through September 30, 2025—the most recent available at the time of the inspection.

³⁷ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

³⁸ 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.

³⁹ 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 1978.⁴⁰ 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.

⁴⁰ 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 Pacific West Health Network (10N5)

Subj: OIG Draft Report—Healthcare Facility Inspection of the VA Phoenix Health Care System in Arizona

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

1. Thank you for the opportunity to review the OIG Draft Report-Health Care Facility Inspection of the VA Phoenix Health Care System in Arizona. I have completed a full review of the draft report and concur with the recommendation provided by the VA Office of Inspector General.
2. I concur with the report and the action plan submitted by VA Phoenix Health Care System.
3. Please contact the VISN 5- Health Service Area 5.3 Regional Quality Management Officer for questions or if additional information is needed.

(Original signed by:)

Tiel Keltner
Interim VISN 5 Deputy Network Director
For
Teresa D. Boyd, D.O.
Veterans Integrated Service Network 5 Director, VHA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 29, 2026

From: Director, VA Phoenix Health Care System (644)

Subj: Healthcare Facility Inspection of the VA Phoenix Health Care System in Arizona

To: Director, VA Pacific West Health Network (10N5)

1. We appreciate the opportunity to review and comment on the OIG draft report—Healthcare Facility Inspection of the VA Phoenix Health Care System. The VA Phoenix Healthcare System concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality and Patient Safety Service.

(Original signed by:)

Elijah J. Ditter
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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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.