US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas

Healthcare Facility Inspection	26-00060-15	November 13, 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 Veterans Health Care System of the Ozarks (the facility) from May 19 through 21, 2026. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to about 60,000 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 found that inconsistent supervisory practices, fear of retaliation, and limited psychological safety across services led employees to hesitate to report patient safety concerns, which increased the risk that issues would remain unreported. This did not align with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, which requires an environment where employees feel safe to report patient safety concerns.[3] The OIG made a recommendation.
- **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 leaders did not include all elements in the facility's policy for communicating test results and did not develop service-level workflows that designate roles of providers and staff in communicating test results to patients, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[4] The OIG made two recommendations.

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[1] VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through June," VHA Support Service Center, accessed June 2, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

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

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

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

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[5] Inspectors found that over half of primary care panel sizes (the number of patients assigned to a care team) exceeded requirements in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[6] The OIG made one recommendation.
- **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 Executive Director takes appropriate steps to implement a data-driven strategy to measure and improve psychological safety across services, with a focus on alleviating employees' fear of retaliation and strengthening their confidence in reporting patient safety concerns, in alignment with Veterans Health Administration Directive 1050.01(1), *Veterans Health Administration Quality and Patient Safety Programs*.
2. The Executive Director takes appropriate steps to update the facility's policy for communicating test results, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
3. The Chief of Staff and Associate Director for Patient Care Services take appropriate steps to develop written workflows, consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients.*
4. The Executive Director takes appropriate steps to manage primary care teams' panel sizes, in accordance with Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

[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.

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). Based on information provided, the OIG considers recommendations 2 and 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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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.[7] 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 shapes an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[8]



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.[9]



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[10]



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.[11]

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[7] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[8] 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.

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

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

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

The Veterans Health Care System of the Ozarks (the facility) has served veterans since 1934 and provides primary, mental health, specialty, and women's health care as well as surgery. The facility has 61 inpatient beds, including in the domiciliary, and a fiscal year (FY) 2025 budget of over $940 million.[12] It offers outpatient care at the medical center in Fayetteville, Arkansas, and at community-based outpatient clinics in Fort Smith, Harrison, and Ozark, Arkansas; Branson, Springfield, and Joplin, Missouri; and Jay, Oklahoma.



Figure 1. *Facility photo.*
Source: "VA Fayetteville Arkansas Health Care," VA, accessed June 9, 2026, https://www.va.gov/fayetteville.

The OIG team inspected the facility from May 19 through 21, 2026. The executive leaders referred to throughout this report include the Executive Director, interim Chief of Staff (since January 2026), interim Associate Director (since March 2026), Associate Director for Patient Care Services (Nurse Executive), and acting Assistant Director (since April 2026). In this report, interim is used to describe a temporary assignment to a vacant position, while acting refers to a position that is filled while the permanent person is out of the office.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[13] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

[12] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. "Trip Pack–Operational Statistics Table FY2026 Through June," VHA Support Service Center, updated June 2, 2026, https://reports.vssc.med.va.gov/Report. (This web page is not publicly accessible.)

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

[14] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[15] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

Executive leaders and employees identified leadership instability as a system shock that affected organizational culture and operational continuity. They reported that the chief of staff position had been vacant since November 2024, and six interim leaders had rotated through the role since. To address the ongoing turnover, executive leaders kept the position posted and screened applicants as they applied. The permanent Chief of Staff was appointed about one month after the May 2026 OIG inspection. Additionally, executive leaders said that when the executive director position became vacant and the Associate Director was temporarily assigned to another location in the summer of 2025, the shifting expectations were difficult to carry out.

Executive leaders explained that leadership instability affected operations because of the limited authority and incomplete access to essential administrative systems while in an acting or interim position, such as those used for staffing actions, performance reviews, and routine approvals. They reported these issues increased the time required to complete tasks and delayed operations.

Employee Experiences

Employees who participated in the OIG questionnaire and interviews described a culture where psychological safety (when employees are comfortable speaking up about safety concerns) was limited, saying they hesitated to speak up due to inconsistent expectations and fear of retaliation. According to patient safety managers and the high reliability organization coordinator, employees in some departments reported feeling unable to submit patient safety reports because supervisors or service leaders were perceived as discouraging these reports. Employees explained that working in small departments made it easy for leaders to identify who submitted a report, increasing fear of retaliation. Patient safety staff also noted fluctuations in anonymous submissions and reports marked as involving fear, which they monitored and escalated as needed. Additionally, documents received showed a steady decline in the number of patient safety reports for the year prior to the site visit in May 2026, which could be due to the fear associated with reporting.

Patient safety managers also mentioned that employees expressed fear of retaliation from service leaders due to inconsistent expectations, punitive responses to reported concerns, and lack of psychological safety. They explained that reluctance to report patient safety events increased the risk that quality issues affecting patient care could go unrecognized. Furthermore, documents provided by the facility showed instances when employees felt reported patient safety events went unaddressed or received no visible follow-up, reinforcing uncertainty about whether the organization was improving its culture.

Despite these concerns, the patient safety team noted that executive leaders supported event reporting by communicating regularly with patient safety managers and reviewing concerns monthly. However, these actions did not fully address the underlying fear of retaliation or lack of psychological safety. VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*

requires a just culture (an environment that allows employees to trust in the reporting system without fear) where employees feel safe reporting patient safety concerns.[16]

The OIG discussed employees' fear of retaliation and concerns about psychological safety with executive leaders, who reported being unaware of the issues despite receiving periodic employee feedback through surveys and safety forums. Following this discussion, executive leaders acknowledged concerning trends and identified strategies to strengthen psychological safety, including steps to improve how they use available data, such as partnering with the high reliability organization coordinator and planning to directly issue feedback questionnaires in the future to encourage more employees to respond.

In addition to psychological safety concerns, the high reliability organization coordinator and patient safety employees stated that primary care and prosthetics employees faced additional operational stressors that hindered workflow and posed safety risks, including communication breakdowns, unsafe ordering practices, and unclear accountability.[17] The coordinator explained that primary care employees entered some orders for prosthetic devices without providing adequate patient education, and providers approved them. Executive leaders acknowledged this concern and reported initiating corrective actions and training.

The OIG is concerned that the reported fear of retaliation, discouragement of reporting, and limited executive leader awareness of these issues may deter employees from reporting patient safety events, which increases the risk that quality-of-care problems may go unrecognized.

Recommendation 1

The Executive Director takes appropriate steps to implement a data-driven strategy to measure and improve psychological safety across services, with a focus on alleviating employees' fear of retaliation and strengthening their confidence in reporting patient safety concerns, in alignment with Veterans Health Administration Directive 1050.01(1), *Veterans Health Administration Quality and Patient Safety Programs*.

_X_ Concur

____ Nonconcur

Target date for completion: April 30, 2027

[16] VHA Directive 1050.01(1).

[17] "High reliability means consistent excellence in quality and safety across all services maintained over long periods of time." The Joint Commission, "High Reliability," accessed May 26, 2026, https://www.jointcommission.org/high-reliability.

Director Comments

The facility leadership recognizes that a strong culture of safety requires employees to know how to report concerns, feel psychologically safe doing so, and receive timely feedback regarding actions taken. To support this culture, the facility has implemented coordinated actions addressing psychological safety, leadership follow-through, fairness and transparency, organizational learning, Just Culture, civility, and whistleblower protections.

For the past four quarters, the facility has administered the quarterly Change Readiness Questionnaire (CRQ) as an organizational risk-sensing and improvement tool. Leadership reviews the results, transparently shares findings with frontline teams, and develops targeted action plans to address identified concerns. Current actions include additional Just Culture education; reinforcement of Just Culture principles through forums and town halls; National Center for Patient Safety (NCPS) Team Training; leader rounding; and closed-loop communication through the "You Spoke, We Listened" process.

Patient safety reporting and whistleblower protection rights are now standing agenda items at monthly Employee Town Halls. These discussions reinforce reporting pathways, reporting trends, lessons learned, employee protections, and the facility's expectation that employees may raise concerns without fear of retaliation.

Patient Safety conducted multiple Joint Patient Safety Reporting (JPSR) system reviewer training sessions addressing substantive review expectations, required information for evaluating and resolving concerns, timely resolution, and employee feedback regarding actions taken. Monthly all-employee safety forums continue to reinforce Just Culture principles, fair and consistent behavioral assessment involving human error, at-risk behavior, and reckless behavior, organizational learning, and psychological safety. The facility is also incorporating the Just Culture Framework as an appendix to the Patient Safety Improvement Program standard operating procedure to reinforce consistent application.

Between April and August 2026, executive leaders and service chiefs completed National Center of Patient Safety (NCPS) Team Training facilitated by the High Reliability Organization Coordinator. The training reinforced leadership practices that promote:

- Environments in which employees feel safe speaking up.
- Strong communication and decision-making under pressure.
- Effective navigation of system challenges.
- Sustained daily reliability for Veterans.

The facility has established a coordinated approach to expand NCPS Team Training facility-wide during FY 2027.

In June 2026, the facility partnered with the National High Reliability Organization Team to adopt an updated leader-rounding application that includes action tracking and employee feedback regarding reported concerns. This provides an additional mechanism to identify, escalate, monitor, resolve, and communicate frontline concerns. The enhanced leader-rounding application has been live at VHSO since October 2026.

The facility has maintained 98 percent compliance with daily Tiered Safety Huddle (TSH) practices across 110 virtual boards. Of 7,051 submitted items, 6,652 have been resolved.

Executive leadership will continue to evaluate effectiveness through recurring culture survey results, survey participation, patient safety reporting trends, concern-resolution data, leader-rounding follow-up, and action-plan monitoring. The facility respectfully requests closure of this recommendation based on submitted evidence, including 100 percent completion of NCPS Team Training by executive leaders and service chiefs; sustained TSH compliance above 95 percent; documented inclusion of employee reporting and whistleblower protections in Employee Town Halls; ongoing all-employee safety forums; JPSR reviewer training; and the additional corrective actions described above.

The Veterans Health Care System of the Ozarks remains committed to fostering an environment in which employees can raise concerns without fear, leaders respond fairly and transparently, employees receive feedback regarding actions taken, and reported concerns contribute to organizational learning and safer care for Veterans.

OIG Comments

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

Veteran Experiences

The veteran experience program analyst described improving veterans' experiences by using new data tools and applications that helped fix problems faster and restore trust more quickly. For example, employees use dashboards that display information from different surveys, which help them identify problems in real time and allow leaders to pinpoint specific clinics, questions, or providers that need attention and then quickly correct issues.

Veteran experience office employees also used a locally developed survey that collects immediate feedback from veterans after their visits. The program analyst said they reviewed the results daily, contacted veterans who reported concerns within 24 hours, and resolved issues before they became long-term problems. According to the veteran experience office employees, the combination of real-time data, focused surveys, and rapid communication created a more responsive system.

In one case, the veteran experience officer described identifying an emerging issue in which veterans felt ignored during urology and podiatry appointments. By reviewing relevant survey questions and speaking with individual veterans, veteran experience office employees determined that the clinical care itself was appropriate, but providers' limited engagement negatively affected veterans' experiences. For example, providers sometimes neglected to greet or welcome the veterans. The veteran experience team reported they provided targeted feedback and coaching to providers on communication and interpersonal engagement, which helped improve provider ratings. The team demonstrated a culture focused on prompt follow-up to resolve concerns and data-informed improvement.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[18] 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.[19]

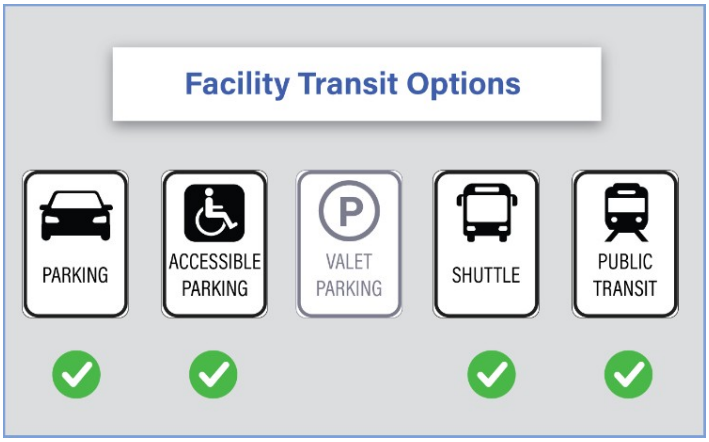


Figure 2. *Transit options for arriving at the facility.*
Source: OIG questionnaire responses, photos, and observations.

General Inspection

On arrival, the OIG team followed clear signs to well-lit parking areas with accessible spaces for those with disabilities, tactile walking surface warnings on ramped sidewalks (sloped curbs with textured ground indicators used to alert visually impaired individuals to hazards or changes in walking paths), and security cameras. A

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

[19] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard: A Supplement to the Architectural Barriers Act Accessibility Standards (ABAAS)*, 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.

public bus stop was within walking distance of the facility's main entrance, and staff reported that they provided shuttle services for veterans to and from the main entrance and other clinic areas.

The main entrance included a covered passenger drop-off area, power-assisted doors, natural lighting, ample seating, and a sufficient supply of wheelchairs. The OIG inspectors also observed televisions with closed captioning in public and patient care areas, which staff also reported were available. Information desk staff and volunteers told the OIG that they assist veterans in obtaining translation services by connecting them with the facility's interpreter services.

Through a staff questionnaire response and interview, the OIG also learned the facility provided hearing aids and assistive listening devices, including personal amplifiers, to hearing-impaired veterans when clinically indicated. For visually impaired veterans, the facility's visual impairment service team offered low-vision evaluations, case management, and adaptive skills training as well as magnification devices and smartphone applications.

Throughout the facility, signs were clear and easy to read, color-coded maps helped with navigation, and elevator panels included braille. During inspections of the emergency department, primary care clinic, intensive care unit, medical-surgical unit, and dental clinic, inspectors found clean patient care areas with no privacy issues. Medical equipment had inspection stickers that indicated preventive maintenance was up to date; furnishings and equipment were clean and in good condition; and medication and supply rooms were secure and contained no expired medications.



Figure 3. *Accessibility tools available to veterans with impairments.*
Source: OIG questionnaire responses and observations.

However, the OIG team found three issues: floor cleaning supplies and a ladder stored in the emergency department's soiled utility room, expired sanitizing wipes in the medical-surgical sterile storage room, and a ladder stored in the intensive care unit's soiled utility room. The presence of ladders and cleaning supplies in soiled utility rooms and expired wipes in sterile storage reflects lapses in infection prevention and safety practices. These conditions increase the risk of cross-contamination and can pose potential harm to veterans and staff by increasing exposure to environmental contaminants. Staff corrected these problems while the team was on-site in May 2026, so the OIG did not make a recommendation.



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

Communication of Urgent but Noncritical Test Results

The OIG team found facility leaders reported an established process for communicating test results to providers and patients; however, the facility's policy was missing elements even though it was updated in April 2026. Further, leaders had not developed service-level workflows (which describe staff roles in communicating test results to patients), as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[20] A lack of service-level workflows can cause delayed or missed communication of abnormal test results and a lag in follow-up actions, which can compromise safety and the quality of care provided to veterans.

On July 11, 2023, VHA published Directive 1088, which required the facility to develop a local policy and service-level workflows within 6 to 12 months. The OIG identified several missed opportunities for the facility to recognize the need to revise its policy and create service-level workflows which included the following:

- On September 20, 2024, VHA amended the directive, clarifying expectations for service-level workflows but did not detail those service-specific roles.[21]
- In April 2026, the OIG requested facility policies and service-level workflows related to test result communications.
- The OIG published reports that cited other facilities where there were identified problems with VHA requirements for test result communication.[22]

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

[21] VHA Directive 1088(1).

[22] Two examples of OIG reports with findings and recommendations on test result communications are VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No. 24-00592-60, March 6, 2025, and VA OIG, *Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia*, Report No. 24-00603-86, March 26, 2025.

Recommendation 2

The Executive Director takes appropriate steps to update the facility's policy for communicating test results, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Executive Leadership Team directed a comprehensive review of VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, and a corresponding updated MCP 11-079, Communication of Test Results to Providers and Patients to align the facility's governing policy with applicable VHA requirements.

The revision operationalizes processes for special circumstances addressed by VHA Directive 1088(1), including coordination before communicating life-changing results to patients with an active High Risk for Suicide Patient Record Flag, updates to alert tracking to include back up reviewers, adopts Oracle EHRM language, and expands on service level workflows which are updated at minimum yearly and located on the facility Communication of Test Results SharePoint.

This corrective action resolves the policy elements identified by the OIG and establishes a comprehensive, Directive-aligned framework. The facility continues to advance quality improvement initiatives focused on strengthening test-result communication and compliance monitoring. External Peer Review Program data demonstrated 90.3 percent compliance in fiscal year 2026 quarter 4. Fiscal year 2026 year-to-date compliance was 10 percentage points higher than fiscal year 2025 year-to-date compliance further reflecting leaders' commitment to Directive compliance. Based on the signed policy, supporting documentation, and demonstrated improvement in compliance, the facility requests closure of Recommendation 2.

Veterans Health Care System of the Ozarks is committed to ensuring timely, reliable, and documented communication of test results to providers and patients and to sustaining compliance with VHA Directive 1088(1).

OIG Comments

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

Recommendation 3

The Chief of Staff and Associate Director for Patient Care Services take appropriate steps to develop written workflows, consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients.*

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Staff and Associate Director for Patient Care Services, with support from Quality and Patient Safety and clinical service leadership, completed the development and review of written service-level workflows for communicating test results. Service leaders confirmed that the workflows defined service-specific roles, responsibilities, escalation pathways, documentation requirements, and processes for communicating results to providers and patients. The workflows were approved through the Medical Executive Council (MEC) process and updated to align with Medical Center Policy (MCP) 11-079, *Communication of Test Results to Providers and Patients*.

The revised MCP incorporates the Service-Level Critical Results Workflows in Appendix A, the Critical Test Results Cascade in Appendix B, and staff communication and documentation standards in Appendix C. Collectively, these appendices establish standardized processes for diagnostic service notification, provider follow-up, direct communication, active acknowledgment, electronic health record (EHR) documentation, escalation when the ordering provider or proxy is unavailable, and communication of life-changing results to patients with an active High Risk for Suicide Patient Record Flag (HRSPRF). The finalized workflows are maintained as controlled operational resources on the facility's Communication of Test Results SharePoint site, allowing service-level processes to be updated while remaining aligned with MCP 11-079 and Veterans Health Administration (VHA) Directive 1088(1), *Communicating Test Results to Providers and Patients*.

These actions address the workflow deficiency identified by the Office of Inspector General (OIG) and establish standardized, accountable service-level processes for communicating test results. Veterans Health Care System of the Ozarks (VHSO) is committed to sustaining timely, reliable, and patient-centered communication through clearly defined responsibilities, standardized workflows, ongoing compliance monitoring, and continuous quality improvement. Based on the approved workflows, MEC approval, and signed MCP 11-079, the facility requests closure of Recommendation 3.

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.

Action Plans and Process Improvements

Inspectors reviewed the most recent Joint Commission report and found that facility staff had addressed identified deficiencies or implemented action plans.[23] The inspection team also reviewed the most recently published OIG facility report and noted that leaders had closed all recommendations.[24]

The chief of quality and patient safety explained that quality management staff randomly audit communications of abnormal test results to identify areas that need improvement. In addition, leaders in women's health, primary care, pathology and laboratory medicine, radiology, and community care reported they audit and review the communication of test results within each service to ensure providers notify patients of abnormal test results requiring action within seven days of results being available, as required by VHA Directive 1088(1).

Despite staff's hesitancy to report patient safety events as explained in the Employee Experience section, leaders explained that once events are reported, facility leaders discussed robust processes for reviewing reported patient safety events within their respective clinical areas. They described strong collaboration across services to prevent events from recurring and improve the quality of patient care. The chief of pathology and laboratory medicine cited a project that improved the process for handling cerebrospinal fluid (surrounds the brain and spinal cord) in the laboratory, which ensured the safety of staff and accurate test results for patients.

Additionally, the systems redesign coordinator discussed two initiatives that brought faster results to providers for pulmonary imaging and mammography. The coordinator shared that in 2025, facility staff completed 35 improvement projects and obtained certification in Lean methodology (a process improvement framework that focuses on eliminating waste, increasing efficiency, and maximizing the value of available resources).

[23] The Joint Commission, *Final Accreditation Report*, *Veterans Health Care System of the Ozarks*, April 10, 2026.

[24] VA OIG, *Comprehensive Healthcare Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas*, Report No. 22-00237-05, October 25, 2023.



VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[25] 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

At the time of the inspection in May 2026, primary care staff reported 24 vacant primary care positions: 9 physicians, 2 floating advanced practice nurses (who are not assigned to a team and provide coverage where needed), 3 registered nurses, 8 licensed practical nurses, 1 advanced medical support assistant, and 1 medical support assistant.

The interim Chief of Staff also identified significant gaps between authorized staffing in primary care and operational needs, which decreased veterans' access to care. For instance, at the Springfield and Joplin outpatient clinics, staffing vacancies reduced appointment access for veterans, increased provider panel sizes (the number of patients assigned to a care team), and placed additional strain on the clinical workforce. Executive leaders noted that attempts to fill primary care provider positions were often unsuccessful because of credentialing (the process to verify a provider's qualifications) delays, small applicant pools, and salary limitations.

In response, primary care leaders described using recruitment strategies, including partnering with a national physician recruiter and facility-based recruiter, offering the VA education debt reduction program, and providing a two-year $20,000 recruitment incentive.[26] They reported no issues hiring registered nurses or advanced nurse practitioners. According to the leaders, the facility had floating staff to help cover vacancies, including 11 nurse practitioners, 14 registered nurses, and 3 licensed practical nurses.

The chief of primary care reported meeting weekly with the patient centered management coordinator (who is responsible for calculating, adjusting, and monitoring panel sizes), supervisory administrative officer, and a program support assistant to review panel data. The chief reported their targets for panel sizes were 1,200 patients for physicians and 900 for

[25] "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.

[26] VHA Handbook 1021.01, *Education Debt Reduction Program Procedures*, May 31, 2012.

nonphysician providers, which reflected the baseline capacities in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[27]

The chief explained that panel capacity percentages are based on the facility's baseline panel size, with 100 percent representing the expected number of patients for a provider. At the time of the inspection in May 2026, the supervisory administrative officer reported that 59 percent of physicians' and 58 percent of nurse practitioners' panels were above 100 percent capacity, and 24 out of 51 panels (47 percent) exceeded 105 percent capacity. The coordinator and chief explained that physician departures led staff to move patients to other providers, which increased panel sizes.

Additionally, assigning full panels to new providers caused them to exceed baseline capacity limits noted in VHA Directive 1406(3), which states that new providers may be set at 50 percent capacity for the first 6 months and reach 100 percent at 12 months. Panel sizes over baseline capacity can lead to staff burnout and reduce the quality of patient care by making it harder for patients to get timely, thorough, and consistent services.

Recommendation 4

The Executive Director takes appropriate steps to manage primary care teams' panel sizes, in accordance with Veterans Health Administration Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.

_X_ Concur

____ Nonconcur

Target date for completion: February 26, 2027

Director Comments

The Veterans Health Care System of the Ozarks concurs with the recommendation. Since the Office of Inspector General site visit, the facility has implemented multiple actions to strengthen Primary Care staffing, optimize provider capacity, and manage patient panel sizes.

Primary Care leadership conducts recurring Improving Capacity, Efficiency, and Productivity (ICEP) reviews to assess appointment utilization, clinic grids, provider productivity, workload, capacity, and panel management. These reviews identify opportunities to improve access and maximize existing clinical resources. As part of this process, leadership evaluates panel accuracy, productivity, return-visit rates, clinic-grid validation, and scheduling/bookability metrics. Providers whose panels exceed 105 percent capacity and meet established

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

benchmarks may have new patient scheduling temporarily paused until panel sizes return to acceptable levels.

The facility completed a review and adjustment of Primary Care physician salaries to support recruitment and retention and approved four full-time Primary Care float provider positions, which are currently being recruited to provide staffing support across Primary Care locations and teams.

To further support recruitment and retention, the facility initiated a special salary review for advanced practice registered nurses (APRNs). Additional interdisciplinary Primary Care positions, including clinical pharmacy practitioners, mental health staff, social workers, nursing staff, and other support personnel, have been approved or are under review.

The facility also implemented Patient Aligned Care Team (PACT) 2.0 training to strengthen team-based care and optimize use of interdisciplinary team members.

The Chief of Staff will continue to monitor staffing, provider capacity, clinic utilization, recruitment efforts, and panel-size data through recurring ICEP reviews. Identified barriers will be addressed through recruitment, staffing adjustments, interdisciplinary support, training, or other corrective actions, as appropriate.

The facility respectfully requests closure of this recommendation based on the steps taken including the completed physician salary review and adjustment; approval and active recruitment of four Primary Care float provider positions; initiation of the APRN special salary review; review and approval of additional interdisciplinary support positions; implementation of PACT 2.0 training; and ongoing ICEP reviews that evaluate provider capacity, clinic utilization, and panel-size management with corresponding pauses when indicated.

The Veterans Health Care System of the Ozarks remains committed to maintaining appropriate Primary Care panel sizes, strengthening recruitment and retention, optimizing provider capacity, and supporting interdisciplinary team-based care to ensure Veterans receive timely, accessible, and reliable Primary Care services.

OIG Comments

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

The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the primary care wait time is longer than 20 days.[28] The supervisory

[28] 38 C.F.R. § 17.4040 (2025).

administrative officer reported wait times of less than 20 days for established patients for FY 2025 through the first two quarters of FY 2026; for new patients, wait times decreased from 30 days in quarter one of FY 2026 to about 23 days in quarter two. To reduce new patient wait times, primary care leaders said they established an internal medicine residency clinic, staffed by physicians in training and supervised by attending physicians, to help expand capacity for new and walk-in patients. Primary care leaders also shifted certain patient management tasks to other team members to give providers more time to see patients; for example, clinical pharmacists managed patients with high blood pressure.

Community Care Staffing and Access to Care

The business manager for community care reported 13 vacancies: 2 medical support assistants, 3 advanced medical support assistants, 1 supervisory medical support assistant, 3 registered nurses, 1 nurse manager, 1 assistant nurse manager, and 2 advanced nurse practitioners. The associate chief of staff of community care explained that since FY 2024, 27 community care positions were eliminated and recruitment was limited to existing vacancies, which made it difficult to restore staffing capacity to pre-reduction levels. This reduction left the program with fewer staff than needed and led employees to work overtime to meet operational demands. The community care department also had 5 floating advanced medical support assistants available to help cover vacancies and manage workload.

A community care staff member reported that the facility's community care referral volume increased by approximately 17,000 from FY 2023 to FY 2025. The associate chief explained the increase was due to a higher number of patients with post-COVID lung and heart issues, as well as more veterans who qualified for community care based on drive time eligibility.

VHA's *Consult Timeliness Standard Operating Procedure* requires community care staff to schedule patients' appointments within 7 days.[29] A community care staff member noted that in FY 2025, staff took an average of 14.8 days to schedule appointments; this decreased to an average of 12.6 days in the second quarter of FY 2026. To continue improving scheduling timeliness, the associate chief reported allowing administrative staff to process community care consults that only require administrative review, while nurses manage consults that require clinical input, including deciding whether the requested care is clinically appropriate. The associate chief also combined teams to improve communication, reduce redundancy, and better manage unplanned leave.

The associate chief also mentioned implementing software that enabled staff to schedule patients directly into community providers' appointment slots; however, few community providers enrolled in the system. According to the associate chief, meeting the seven-day scheduling

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

requirement was a challenge because of delays with community providers accepting VA referrals.[30]



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

Health Care for Homeless Veterans

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

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).[32] 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)."[33]

[30] VHA, *Patient Safety and Quality Events in Community Care: Reporting*, *Investigation*, *and Improvement Guidebook*, November 2024.

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

[32] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contracted residential services programs include both emergency residential services and low-demand safe haven programs. For 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.

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

Performance and Improvement Highlights

- The facility's HCHV program manager said staff identify veterans experiencing homelessness through facility and community provider referrals, self-referrals, community outreach, and the National Call Center for Homeless Veterans.[34] The program manager also stated that social workers and peer support specialists conduct community outreach in shelters, soup kitchens, and day centers. Additionally, they offer training to community providers and participate in annual point-in-time counts (tallies of individuals experiencing homelessness).[35]
- The program manager reported that staff conducted outreach to veterans and community providers throughout the entire service area, which was possible due to three additional outreach social workers hired within the last three years. The HCHV senior social worker explained the additional staff also improved the quality of care by allowing more time during initial visits to meet all of veterans' basic needs, including securing transitional housing or temporary shelter the same day. Previously, staff needed to schedule multiple appointments to meet these needs due to significant workload demands.
- However, staff also noted burdens from increased administrative requirements, such as a January 2025 VA memorandum requiring permission from the VA Chief of Staff to attend community events.[36] This requirement prevented staff from participating in the 2025 point-in-time count and limited the educational activities of veterans justice outreach staff because decisions were not available in time. The program manager estimated that this change resulted in staff missing up to five events per month among all facility homeless programs. They believed that veteran identification and enrollment were not affected because of strong community partnerships but noted this reduced the facility's ability to provide homeless program education within the community. The program manager said that in recent months, VA modified the approval process, which improved staff's ability to attend most outreach events.
- The program manager shared that barriers to permanent housing included an insufficient number of affordable housing units. Additional challenges included

[34] "VA Homeless Programs, National Call Center for Homeless Veterans," VA, accessed September 3, 2024, https://www.va.gov/Homeless/NationalCallCenter.

[35] Local HUD offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," VA, last updated June 1, 2026, https://www.va.gov/homeless/pit_count.

[36] Chief of Staff (00A), "Temporary Review of Certain Department of Veterans Affairs (VA) Communications and Travel (VIEWS 12680106)," memorandum to Under Secretaries, Assistant Secretaries, and Other Key Officials, January 22, 2025.

limited community resources, lack of public transportation, and inadequate numbers of shelter beds. The program manager reported that rising rents made housing unaffordable for some veterans and contributed to homelessness.

- The facility exceeded the HCHV1 (exits to permanent housing) target in FY 2025 and the first two quarters of FY 2026. The program manager credited this success to engaging with the HUD-VASH rental voucher staff early while veterans were in the transitional housing program.
- For the same review period, the facility met the HCHV2 (negative exits) target for FY 2025 through quarter one of FY 2026 but fell short for the second quarter of FY 2026. The program manager said the target was difficult to meet because many veterans were in early recovery from substance use disorders, with a high risk of relapse and removal from the program. However, the program manager described adding a dedicated HCHV liaison for the contracted emergency residential services program, which enabled program staff to increase weekly visits. Staff were then able to provide additional services and treatment referrals for veterans at risk of discharge.

Housing and Urban Development-Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[37] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[38]

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).[39]

Performance and Improvement Highlights

- The program provides services to veterans at four sites in the facility's service area: Fayetteville and Fort Smith, Arkansas, and Joplin and Springfield, Missouri. The

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

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

[39] 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.*

program supervisors reported recruiting for two vacancies that would fully staff the program and provide adequate resources.

- The facility met the voucher use (HMLS3) target for FY 2025 and almost met it, at 89.95 percent, in quarter two of FY 2026. The supervisors credited this success to the housing specialists, who help veterans find housing quickly, and case managers, who coordinate with other facility services such as mental health or substance use treatment to support stability.
- To decrease the risk of veterans leaving the program before moving into permanent housing, program supervisors implemented a process change in April 2025. Veterans now work with multiple staff at enrollment, including housing specialists who focus on finding housing, and case managers and peer support specialists who address other needs, psychosocial stressors, or crises. The supervisors said the new method increases veterans' stability and improves their likelihood of securing permanent housing.
- Barriers to permanent housing include obtaining personal identification, such as birth certificates; limited affordable housing; and few landlords willing to rent to veterans with histories of evictions or poor credit. One supervisor noted that Fayetteville appears on several "best places to live" lists, which caused the population and rental prices to increase. Another supervisor explained that veterans also compete with university students for housing in Fayetteville, but that targeted efforts, such as an incentive payment, have helped keep current landlords engaged in the program.
- The facility was below the employment (VASH3) target for FY 2025. A supervisor explained that the shortfall was because staff were not updating veterans' employment status in the homeless program database. After identifying the issue, supervisors and staff began to review data quarterly to ensure accuracy. During the first two quarters of FY 2026, the facility exceeded the target.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[40] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care,

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

services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[41]

Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025 and FY 2026 through quarter two. Veterans justice outreach coordinators described how each jail in their service area operated independently and some counties used veteran verification methods and resources, while some ask veterans to self-identify military service. The coordinators expressed concern that veterans eligible for the program are sometimes missed, as veterans do not always self-identify when booked. A coordinator noted that in more rural areas, it was a challenge to identify veterans, so staff partnered with local law enforcement agencies to develop identification methods. Program staff also worked with probation and parole officers, public defenders, criminal defense attorneys, and law enforcement staff to identify and enroll veterans after incarceration, ensuring veterans received timely support.
- Staff described how their participation in law enforcement training improved collaboration with community officers, who began contacting program specialists when they encountered veterans with mental health needs. Staff shared an example that showed how this approach led to veterans being referred to treatment rather than arrested. For a veteran in the HUD-VASH program who contacted 911 repeatedly for nonemergency needs, the responding officer recognized their mental health problem and contacted facility staff for support.
- The coordinators stated that veterans treatment courts evolved through adoption of best practices and addressed common needs of veterans, such as homelessness, employment, education, medical and mental health care, and substance use treatment.[42] A coordinator told the OIG that treatment courts in Missouri accept all veterans, even if they are not eligible for VA health care, increasing the provision of services. Coordinators shared examples of positive outcomes, including program graduates over the years who became court mentors for other veterans or improved their lives in other ways.

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

[42] A veterans 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.

Conclusion

To assist leaders in evaluating the quality of care at the Veterans Health Care System of the Ozarks, the OIG conducted an inspection across five domains. The OIG made four recommendations related to employees' psychological safety and fears of retaliation, test result communications, and primary care panel management. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendations 2 and 3. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[43] 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 19 through 21, 2026, and 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.[44] 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.*[45]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[46] The OIG acknowledges potential bias because the facility liaison selected staff 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.

[43] The All Employee Survey and accreditation reports covered the time frame of October 1, 2023, through April 10, 2026.

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

[45] 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.

[46] 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.[47] 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.

[47] 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 22, 2026

From: Network Director, VISN 4: VA Heart of America Health Network

Subj: Healthcare Facility Inspection of the Health Care System of the Ozarks in Fayetteville, Arkansas

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

VISN 4: VA Heart of America Health Network has reviewed and concurs with the findings, recommendations, and submitted action plan for the Healthcare Facility Inspection of the Health Care System of the Ozarks in Fayetteville, Arkansas.

(Original signed by:)

Angela Athmann
Interim Deputy Network Director
For
Fernando O. Rivera, FACHE
Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 15, 2026

From: Director, Department of Veterans Affairs (VA) Fayetteville VA Healthcare System

Subj: VA Office of Inspector General (OIG) Report, Healthcare Facility Inspection of the Veterans Health Care System of the Ozarks in Fayetteville, Arkansas (2026-00060-HI-0026)

To: Director, Department of Veterans Affairs (VA) Veterans Integrated Service Network

1. We appreciate the opportunity to review and comment on the OIG draft report. The Fayetteville Healthcare System concurs with recommendations 1 through 4 that were made to the facility.
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 & Risk Management.

(Original signed by:)

Martha A. Smith, EdD, RD
Executive Director

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.