US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Columbia VA Health Care System in South Carolina

Healthcare Facility Inspection	26-00072-10	November 6, 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 Columbia VA Health Care System (the facility) from May 19 through 21, 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 98,300 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

The OIG inspection did not reveal issues that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **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.

[1] VHA classifies facilities based on their complexity level. High complexity facilities have "medium-high-volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 7) Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center*, last updated January 16, 2026.

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

[3] 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.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C).[4] No further action is required.



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[4] In December 2025, VA announced plans to reorganize VHA's management structure. 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.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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



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



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



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



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.[9]

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

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

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

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

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

The Columbia VA Health Care System (the facility) includes a medical center in Columbia (the Wm. Jennings Bryan Dorn VA Medical Center) and seven community-based outpatient clinics. In fiscal year (FY) 2025, the medical care budget was approximately $1.3 billion. It had 152 beds and served about 98,300 veterans.[10]



Figure 1. *Facility photo.*
Source: Photo taken by OIG inspector.

The OIG inspected the facility from May 19 through 21, 2026. The executive leaders referred to throughout this report include the Acting Medical Center Director (Director) (since November 2025), Acting Chief of Staff and Acting Associate Director (both since January 2026), Associate Director for Patient Care and Nursing Services, and Assistant Director.

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.[11] 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).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

System Shocks

Executive leaders identified several system shocks that disrupted normal operations during the 12 months preceding the May 2026 inspection. They explained the return-to-office mandate, federal hiring freeze (in effect from January 20, 2025, to October 15, 2025), and widespread

[10] VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 7) Wm. Jennings Bryan Dorn VA Medical Center*, last updated January 16, 2026.

[11] 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.

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

[13] 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.

concerns about potential job loss that negatively affected employees' morale.[14] Leaders stated that existing methods such as rounding (spending time in work areas to speak with employees) and open communication channels helped ensure employees received timely answers to their questions during this challenging time.

Leaders said another significant event occurred when primary care experienced gaps between authorized staffing positions and operational needs, which increased pressure and workload on existing employees. The primary care vacancies and their effects are further expanded on in the Integrated Veteran Care section. The Director elevated the issue to the Veterans Integrated Service Network (VISN), used the Clinical Resource Hub (which provides services in areas when needed), temporarily assigned nurse practitioners, referred eligible veterans to community care, and continued to recruit and hire new providers for primary care.[15] The Acting Chief of Staff stated that executive leaders did their best to mitigate any negative effects on veterans' care, such as longer appointment wait times.

[14] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Acting Chief Operating Officer, VA, "Position and Organizational Chart Management (VIEWS 13223853)," memorandum to Veterans Integrated Service Network (VISN) Directors, November 20, 2025.

[15] VA administers healthcare services through a nationwide network of regional systems referred to as VISNs. "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize VHA's management structure. 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. 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.

Employee Experiences

Responses to the OIG questionnaire showed employees felt comfortable reporting patient or employee safety concerns (see figure 2). Leaders held quarterly safety forums to discuss their priorities, help employees understand ongoing efforts, and identify improvement opportunities. In addition, the Acting Associate Director highlighted the Patient Safety Lessons Learned forum, which provides feedback to employees on all anonymous submissions to the Joint Patient Safety Reporting system.[16]

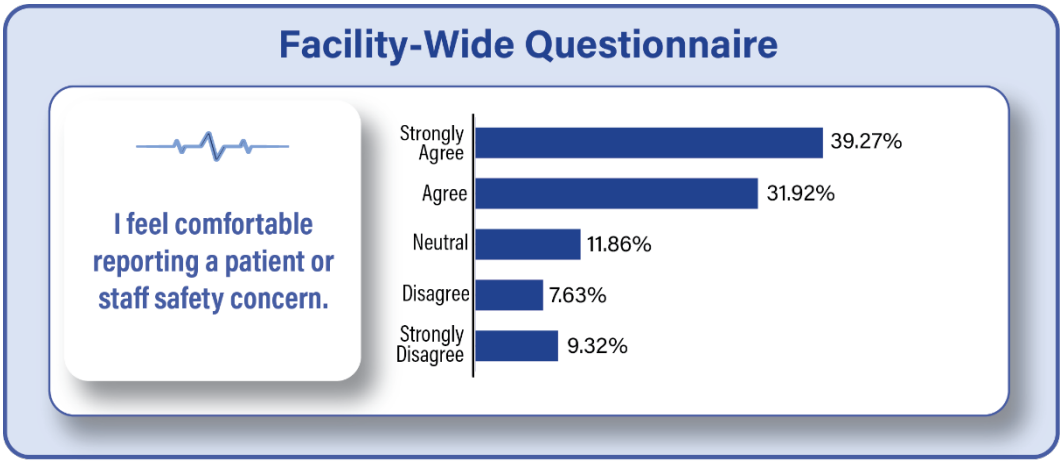


Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

More than half of respondents cited caring for veterans and pay and benefits as top reasons they stay at the facility. However, nearly half identified stress and burnout as reasons they would leave. The Associate Director for Patient Care and Nursing Services reported that leaders are preparing to administer a survey to assess employee burnout, with a focus on workload, stress, and other contributing factors.

Executive leaders can enhance the employee experience through consistent communication, visible and engaged leaders, and opportunities for professional development. The Acting Chief of Staff reported using tiered huddles (a series of meetings with employees and leaders at various levels) to communicate with employees. The Director also highlighted the facility's newsletter, which disseminates key updates, news, and other relevant information. Additionally, the Acting Chief of Staff outlined several key development programs, including the Strategic Tools Empowering Mobility (STEM) program that offers comprehensive training opportunities to support professional growth for entry-level employees.

[16] The Joint Patient Safety Reporting system is a database employees use to document patient safety events, including medical errors and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, *Version 9.0*, March 2026.

Veteran Experiences

Patient advocates' responses to an OIG questionnaire indicated facility employees were responsive to and effectively addressed veterans' concerns, a commitment underscored by the Director's statement that it was important to not fail a single veteran.

Executive leaders acknowledged that the facility's FY 2025 VSignals outpatient score of 91 percent was less favorable than VHA's average of 94 percent. They attributed the score to vacancies in primary care staffing (as discussed in the System Shocks section) and issues with the facility's telephone operations, such as delayed call pick-up times. To address telephone concerns, supervisors use call management tools to monitor call activity, employee availability, and workload distribution. The Director stated that business office leaders also track daily call volume, average time to answer, number of abandoned calls, and other performance indicators, which they report daily to facility leaders. In FY 2025, the average abandonment rate was 11.2 percent, with an average time to answer of 60 seconds. For FY 2026 quarters one through three, the facility lowered its average abandonment rate to 9.3 percent and reduced its average time to answer to 59 seconds.

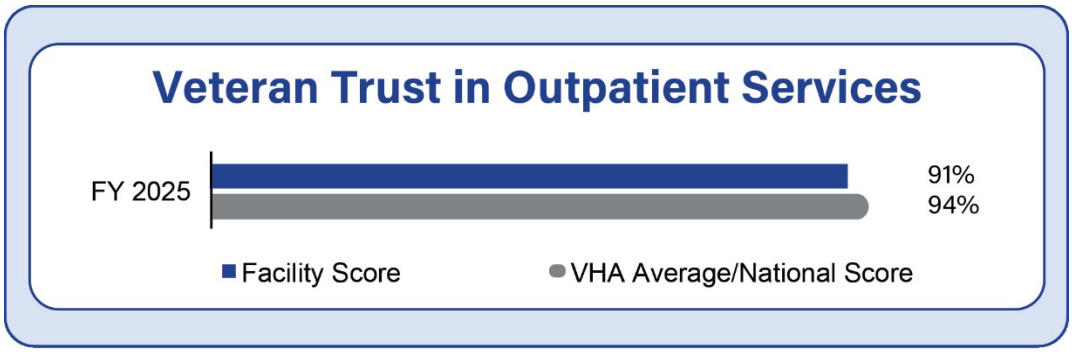


Figure 3. *Veteran trust in outpatient services.*
Source: VSignals data.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[17] 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.[18]

General Inspection

The OIG team easily navigated to the facility, which had clear directional signs and available parking, including accessible spaces for those with disabilities. The facility's parking garage had bright lighting, security cameras, and emergency call boxes on each level. The team also observed shuttle services on campus and public bus stops near the facility.

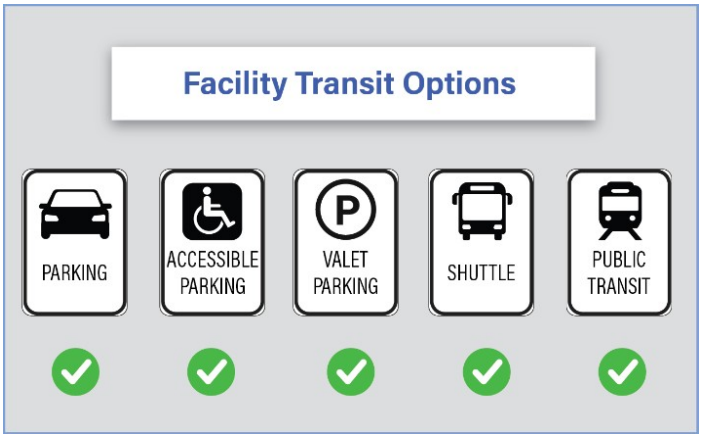


Figure 4. *Transit options for arriving at the facility.*
Source: Inspector observations, facility liaison questionnaire, and parking map.

The main entrance featured power-assisted sliding doors, a covered area for patient drop-off and pick-up, and valet services. The entrance was welcoming with natural light, ample seating, and available wheelchairs.

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

[18] 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.



Figure 5. *Accessibility tools available to veterans with impairments.*
Source: Inspector observations, facility liaison questionnaire, and parking map.

The OIG team observed volunteers greeting and assisting veterans, and employees at an information desk answering questions and helping with navigation. Employees reported they use written communication or other adaptive techniques, such as wireless communication devices, to assist those with hearing impairments; they also escort veterans with visual impairments to their appointments when needed. Facility staff also provided documents showing that translation services were available.

The OIG team observed maps on the walls throughout the facility that made navigation easy. The team noted additional accessible features such as large-print signs, braille room labels, and elevators with braille and audio cues. These measures help ensure veterans can safely navigate the facility.

The OIG team inspected the medical-surgical and intensive care units, emergency department, primary care clinic, and community living center and found they were generally clean and well-maintained. The team also found no issues regarding safety, privacy, or security.

PATIENT SAFETY

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

Communication of Urgent but Noncritical Test Results

The OIG team found the facility had a test result communication policy and service-level workflows describing staff members' roles in the process that met the requirements of VHA Directive 1088(1), *Communicating Test Results to Providers and Patients.*[19] The directive also requires providers to communicate abnormal test results that need action to patients within seven days of them being available. Quality management staff said they monitor staff's

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

adherence to this requirement through the External Peer Review Program and report results quarterly to facility leaders.[20]

The OIG team reviewed the facility's performance data for FY 2025 and the first two quarters of FY 2026 and found that staff notified patients of abnormal results within seven days over 90 percent of the time. Timely notification of test results requiring action is important because delays may postpone follow-up evaluation or treatment, which can increase the risk of missed or worsening clinical conditions. A coordinator for the External Peer Review Program described notifying providers' service chiefs when delays occur. The service chiefs then determine the cause of the delay and take action as needed, such as re-educating the provider. The chiefs report the outcome to the coordinators, who track and share this information with executive leaders.

Action Plans and Process Improvements

The OIG team reviewed the previous OIG comprehensive healthcare inspection report from January 2024 and found all recommendations were closed.[21] Additionally, an accreditation staff member reported the facility had no open or overdue action items related to the communication of test results. Quality management staff said the facility's continuous readiness committee monitors all action plans related to oversight findings and recommendations. To track progress, staff provide updates during monthly committee meetings until the oversight body verifies the facility has implemented the required actions and closes the recommendations. After closure, process owners for the findings monitor sustainment for three to six months and provide evidence of continued improvement—such as audit data—monthly to quality management staff.

Service leaders and a quality management staff member said they identify performance improvement opportunities by reviewing Joint Patient Safety Reporting system entries, facility performance data, and suggestions from staff. To promote accountability and timely progress for patient safety improvements, quality management staff created workgroups in which an executive leader works with the process owners for projects. For example, the Associate Director for Patient Care and Nursing Services leads the workgroup for improvement actions related to nursing processes. During monthly meetings, workgroup members review progress and identify barriers that could delay or hinder improvements.

[20] The External Peer Review Program "provides an independent review of medical records to assess the quality of both inpatient and outpatient care provided" by VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, accessed April 21, 2026, https://vaww.qps.med.va.gov/divisions/api/pm/cpm/cpm. (This site is not publicly accessible.)

[21] VA OIG, *Comprehensive Healthcare Inspection of the Columbia VA Health Care System in South Carolina*, Report No. 23-00009-57, January 25, 2024.



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

Facility staff provide primary care across eight locations in the region, supported by more than 70 primary care teams. In April 2026, a facility document showed vacancies for 31 of 91 providers, 8 of 102 registered nurses, 33 of 109 licensed practical nurses, and 8 of 82 medical support assistants. Leaders reported that the January 2025 hiring freeze made it hard to keep provider candidates (those who had applied for jobs). The facility had already planned a slowdown in hiring before the freeze, which further limited recruitment and made it difficult to hire new staff and replace those who left. Leaders said that lengthy processes meant candidates often accepted other job offers.

The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time for primary care is greater than 20 days.[23] The OIG team found that in FY 2025, wait times for primary care appointments averaged 20 days for new patients and 4 days for established patients. By May 12, 2026, the new patient wait time had increased to approximately 41 days and established patient wait times averaged 6 days. In the fourth quarter of FY 2026, the average new patient wait time was 30 days, and the established patient wait time remained unchanged. However, the average wait time for primary care in the community was approximately 69 days in FY 2025 and 77 days in the fourth quarter of FY 2026.

Primary care leaders and staff said provider vacancies contributed to longer appointment wait times. Staff expressed concern that the vacancies caused patients to be seen by different providers outside their assigned teams, which may affect continuity of care for patients with many care needs. Primary care leaders explained that to improve access, clinics used the VISN's Clinical Resource Hub, reassigned staff across locations, employed fee-based providers (health professionals hired by VA and paid per service), and offered Saturday clinics. Leaders said fee-based providers have been instrumental in maintaining patient care with many being former employees who are familiar with the patient population. Primary care leaders said recruitment efforts added five new providers and more were expected.

[22] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.
[23] 38 C.F.R. § 17.4040 (2025).

Community Care Staffing and Access to Care

OIG inspectors found that in FY 2025, community care staff averaged 26 days to schedule veterans' appointments for consults (requests for care outside of the facility) and averaged 60 days in May 2026, which exceeds the 7-day target in VHA's Office of Integrated Veteran Care *Consult Timeliness Standard Operating Procedure*.[24] Community care leaders and staff said vacancies along with increased consult volume affected their ability to follow up with patients, coordinate care, and process consults (including appointment scheduling). Leaders also said barriers to meeting the 7-day scheduling target included the time it takes for community providers to review consults and for community care staff to make multiple attempts to contact patients for scheduling. The workforce allocation tool, which estimates staffing needs based on workload, showed the facility needed 43 more staff, and leaders said they had 41 in the recruitment process. Leaders had a contract for 20 additional staff to fill the gap until they arrive. The OIG did not make a recommendation based on the robust, active recruitment efforts to fill the large number of staff vacancies.

The consult volume was 99,985 in FY 2025 and had already reached 74,863 in FY 2026 (as of May 2026). Community care staff reported the increased consult volume was due to the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018 and the Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, which expanded community care, and certain specialties such as pulmonology (lung specialists) being unavailable at the facility.[25] Facility documents showed pulmonology community consults increased by 1,264 in FY 2025 from the previous year and reached 3,646 in FY 2026 (as of August 20, 2026). Community care leaders and staff said to help handle consult volume, staff work overtime and receive assistance from other departments; however, timely processing remained a challenge.

Community care leaders and staff discussed a process improvement they implemented in January 2026: an automated tool that identifies patient information within electronic fax records, which shortened sorting time and helped reduce the backlog of records requests from 2,124 to 501.

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

[25] Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act, Pub. L. No. 118-210, 138 Stat. 2706 (2025).



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

Performance and Improvement Highlights

- The facility's program met the exit to permanent housing (HCHV1) target for FY 2025 and the first two quarters of FY 2026. The HCHV program coordinator said the team works with each veteran to identify barriers and develop realistic housing plans.

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

[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. 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.

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

- The program also met the negative exits (HCHV2) target for FY 2025 and the first two quarters of FY 2026. Staff attributed their success to a strong team culture; addressing veterans' concerns about program services at an early stage; and coordination with mental health, medical, and social support teams as needed.
- A key strength of the HCHV program is its dedicated motor vehicle operator, who transports veterans to medical appointments, food banks, court hearings, job interviews, and other essential services to help them maintain housing. Dedicated transportation support also allows social workers to focus on helping veterans acquire housing and government benefits.

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 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's program exceeded both the voucher use (HMLS3) and employment (VASH3) targets for FY 2025 and the first two quarters of FY 2026. Collaboration with eight public housing agencies, resources from the Supportive Services for Veteran Families Program, an internal tracking system that provides real-time visibility on veterans' statuses, and assisting with completing voucher applications enabled staff to quickly help veterans find housing and employment.[32]

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

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

[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] The Supportive Services for Veteran Families "program provides supportive services to very low-income Veteran families in or transitioning to permanent housing." VHA Directive 1162.07(1), *Supportive Services for Veteran Families Program*, September 13, 2023, amended March 7, 2025.

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]

Performance and Improvement Highlights

- The facility's program met the enrollment (VJP1) target in FY 2025 but missed it for the first two quarters in FY 2026. Staff explained that two program vacancies, extended drive times covering the large service area, and time-consuming data-entry requirements have limited their capacity to complete documentation on time, negatively affecting their ability to meet the target. The program supervisor explained they plan to recruit for the vacant positions, which will help cover the large service area.
- Staff added that they work with the local police to identify veterans during their initial contact so they can coordinate with the program. Staff then connect veterans to services such as mental health care to help treat those with underlying behavioral conditions that can increase the risk of incarceration.

Conclusion

To assist leaders in evaluating the quality of care at the Columbia VA Health Care System, the OIG conducted an inspection across five domains. The OIG did not make recommendations following this inspection. 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.

[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.*

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.[35] 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.[36] 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.*[37]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[38] 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.

[35] 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.

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

[37] 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.

[38] 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.[39] 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.

[39] 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 11, 2026

From: Director, VA Southeast Health Network (10N2)

Subj: Healthcare Facility Inspection of the Columbia VA Health Care System in South Carolina

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

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Facility Inspection of the Columbia VA Health Care System in South Carolina. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I concur with the response provided by the facility.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
3. Should you have any questions or require further information, please contact the VISN 2 Quality Management Officer.

(Original signed by:)

Wendell Jones, MD, MBA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 5, 2026

From: Director, Columbia VA Health Care System (544)

Subj: Healthcare Facility Inspection of the Columbia VA Health Care System in South Carolina

To: Director, VA Southeast Health Network (10N2)

1. We appreciate the opportunity to review and comment on the OIG draft report.
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 & Patient Safety.

(Original signed by:)

Bryan E. Arnette, FACHE
Executive Director

OIG Contact and Staff Acknowledgments

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