US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Jackson Healthcare System in Mississippi

Healthcare Facility Inspection	25-00191-212	September 9, 2025

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA Jackson Healthcare System (facility) from January 13 through 16, 2025.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. In an interview, executive leaders identified turnover in leadership positions as a system shock. They stated that nearly four years previously, the executive leadership team, except the Associate Director, left the facility. There were more changes with the executive leaders over the next several years, as well as changes with service line leaders. These changes contributed to instability in the workforce and a loss of knowledge and experience. The leaders attributed the turnover to retirements, promotions, and moves to larger facilities.

The OIG found that All Employee Survey scores improved from fiscal year 2022 through fiscal year 2024 for communication, information sharing, transparency, best places to work, no fear of

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

reprisal, and psychological safety.[2] The facility outscored VHA's averages in the communication, information sharing, transparency, and best places to work categories in fiscal years 2023 and 2024. Executive leaders attributed the improvements to reviewing survey scores during town halls, with staff in each service developing an action plan to address areas of concern. Leaders also said they visit all areas of the facility to speak with staff directly about their concerns, and they have an open-door policy.

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

On entering the facility's site, the OIG found directional signs to a covered patient loading zone and parking area. There is a public bus stop and sheltered waiting area directly in front of the main entrance. The main entrance lobby is open and well-lit by a mix of natural and florescent lighting. The interior signs are clear and easy to read, with some containing pictograms for veterans to easily locate areas. There is also an information desk with staff who direct and escort veterans to appointments as needed. The OIG found the facility to be clean and well-maintained.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG determined the facility has a policy to communicate abnormal test results to ordering providers and patients, assign a surrogate when an ordering provider is unavailable, and communicate results outside regular clinic hours and during transitions in care.

Leaders implemented processes to reduce providers' delays in communicating test results, such as adding a test result communication requirement to providers' performance evaluations for accountability and continuous improvement. Additionally, leaders provided training on view alerts and added nurses to the alert management system to help monitor and communicate test

[2] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development. "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

results.[3] Leaders also initiated process improvement projects to increase compliance, and staff reported data monitoring results to facility committees. The OIG also examined oversight reports and surveys involving the facility for the past three years and did not find any open recommendations. Facility leaders described processes to monitor action plans for recommendation closure and ensure sustained improvement.

The Chief of Staff and quality management staff said they identify patient safety concerns and opportunities for improvement through various methods, such as audits and patient safety reports. In addition, they provide staff with performance improvement cards from which they share their ideas, and the team determines if the suggested ideas are something to immediately initiate or if they warrant a more formalized action plan.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[4]

Facility leaders reported vacancies across primary care positions. Leaders reported they were in the process of recruiting and hiring providers and nurses but had not received approval to hire medical support associates. Staff expressed concern with panel sizes, the number of patients assigned to a care team, and the amount of work required by primary care providers.

In an interview, staff told the OIG that for over a year, the facility lacked a full-time principal facility coordinator, who monitors and reports on panel sizes, capacity levels, and appointment wait times. The former coordinator discussed covering the position as a collateral duty and are only able to complete minimal data validation. Leaders acknowledged that current primary care data may be inaccurate. The OIG made one recommendation.

Staff said they discuss concerns with direct supervisors but do not receive any follow-up information from executive leaders. Recently, staff brought up concerns about inefficiencies at the facility's call center and insufficient time to complete administrative work. Leaders stated they were working on both issues. Staff added that they initiate process improvement projects within their own team, but the information is not shared because each team operates differently.

[3] A view alert is an electronic notification in a computerized patient record system designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, Office of Information & Technology (OI&T), *Computerized Patient Record System (CPRS) User Guide: GUI Version,* October 2024.

[4] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. Overall, staff said they felt supported by facility leaders; and shared a commitment to communication and teamwork. Each program's staff worked with several community partners to meet the needs of the veterans. The programs had several unique practices to support homeless veterans:

- Food pantry operates at the facility once a month, so staff can pick up food and deliver it to veterans
- First in the Veterans Integrated Service Network to use vouchers to place aging veterans in assisted living facilities where they can live independently but with a built-in support system[5]
- Partners with the Progressive insurance company for an annual car giveaway to homeless veterans which provides a veteran with a life-changing opportunity to have reliable transportation to get to work and appointments, and to see family and friends
- Mississippi College School of Law provides legal services for veterans with criminal or legal needs

What the OIG Recommended

The OIG made one recommendation.

1. The facility Director ensures staff review primary care panel sizes and capacity levels to ensure they are accurate.

[5] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see appendixes C and D and the response within the body of the report for the full text of the directors' comments). The OIG considers the recommendation open to allow time for the facility Director to submit documents to support closure. The OIG will follow up on the planned actions for the open recommendation until they are completed.

JULIE KROVIAK, MD
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Jackson Healthcare System
Jackson, Mississippi
Level 1c-High Complexity
Hinds County
Hospital Referral Region: Jackson

Description of Community

POPULATION

Female **685,689**	Male **643,100**
Veteran Female **8,958**	Veteran Male **60,807**

Homeless - State **1,196**
Homeless Veteran - State **139**

MEDIAN INCOME

$40,895

EDUCATION

81% Completed High School
53% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **288**

SUBSTANCE USE

19.7% Driving Deaths Involving Alcohol
13.9% Excessive Drinking
169 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	453,567
Carpool	51,634
Work at Home	16,164
Other Means	7,658
Walk to Work	6,563
Public Transportation	2,138

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**44 Minutes, 38 Miles**
Specialty Care	**79 Minutes, 79 Miles**
Tertiary Care	**82 Minutes, 82 Miles**

Access to Health Care

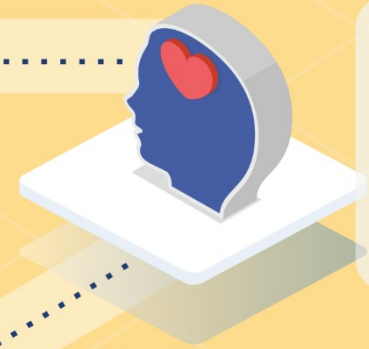
ACCESS

VA Medical Center Telehealth Patients **10,905**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	31%
<65 without Health Insurance	19%

Health of the Veteran Population

159 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

10,802

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.53 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
21	34

Health of the Facility

UNIQUE PATIENTS

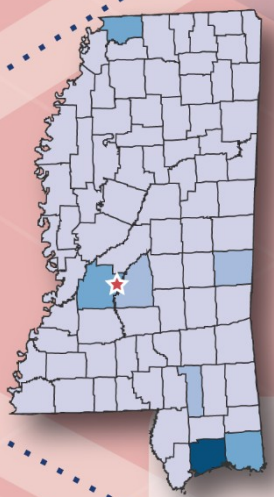
Unique Patients VA and Non-VA Care	41K
Unique Patients VA Care	38K
Unique Patients Non-VA Care	25K

COMMUNITY CARE COSTS

Unique Patient $8,125	Outpatient Visit $298
Line Item $112	Bed Day of Care $122

STAFF RETENTION

Onboard Employees Stay <1 Yr	14.45%
Facility Total Loss Rate	11.72%
Facility Retire Rate	3.21%
Facility Quit Rate	7.28%
Facility Termination Rate	1.12%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.02% 2.76% 5.49% 8.23% 10.96% 13.68%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection cyclical review program to help accomplish its mission. Inspection teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

Healthcare Facility Inspection reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

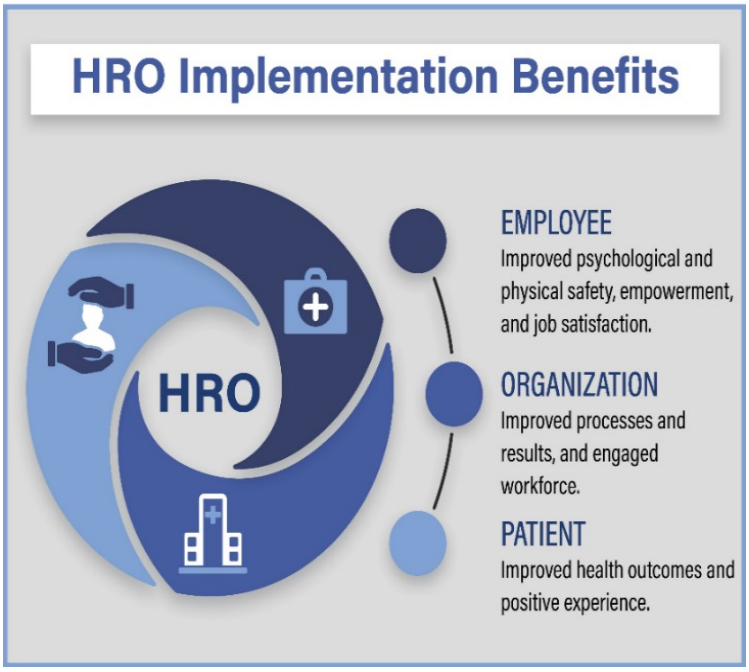


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

inspectors observed how facility leaders incorporated high reliability principles into their operations.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Content Domains

Figure 3. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The VA Jackson Healthcare System (facility) began caring for veterans in 1946. The facility serves 53 Mississippi counties and 3 Louisiana parishes; has the main campus and an outpatient clinic in Jackson and seven community-based outpatient clinics throughout Mississippi. In fiscal year (FY) 2024, the facility had a budget of $527,613,230 and provided care to 41,370 veterans. The facility had 136 operating beds (77 hospital, 27 domicillary, and 32 community living center beds).[13]

The OIG inspected the facility from January 13 through 16, 2025. The executive leaders consisted of the interim Medical Center Director (Director), Associate Medical Center Director, Chief of Staff, Deputy Chief of Staff, Associate Director for Patient Care Services/Nurse Executive, acting Deputy Associate Director for Patient Care Services, and Assistant Medical Center Director. During the OIG visit, the interim Director announced transitioning to the permanent director position.[14]

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp. "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_CLC.

[14] The interim Director assumed the role of Medical Center Director on February 23, 2025.

[15] 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.

[16] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19]

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In an interview, executive leaders identified turnover, especially among leaders, as a system shock. The leaders stated most of the executive leadership team left employment about four years prior and, since, there has been multiple changes to the team as well as to leaders in community care, the community living center, Emergency Management Service, and Physical Medicine and Rehabilitation Service.[20]

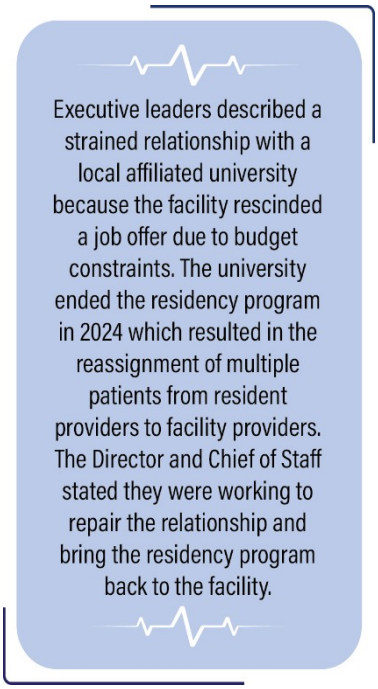


Figure 4. *System shock. Source: OIG interview with executive and facility leaders.*

Leaders said the multiple changes created instability within the workforce and resulted in a loss of knowledge and experience. However, over the past year, leaders said they have noticed a positive shift in the facility culture, with staff now feeling empowered to speak up about their concerns, request resources to support their work, and submit patient safety reports.

[17] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[19] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

[20] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

The interim Director announced being appointed to the permanent director position; however, several other team members were in acting or interim roles.[21] Leaders attribute the turnover to retirements, promotions, and moves to larger facilities or other states. They added that it was difficult to recruit and retain healthcare providers in Mississippi because they leave for better jobs and higher pay; however, once acclimated to the facility and community, they dedicate themselves to caring for veterans.

The leaders also said they have embraced the HRO principles by ensuring consistency and accountability across the facility and encouraging staff to voice their concerns. Although the executive leadership team is relatively new, the OIG found they are dedicated to the facility, work closely together, and embrace and promote the HRO principles.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[22] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[23] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[24]

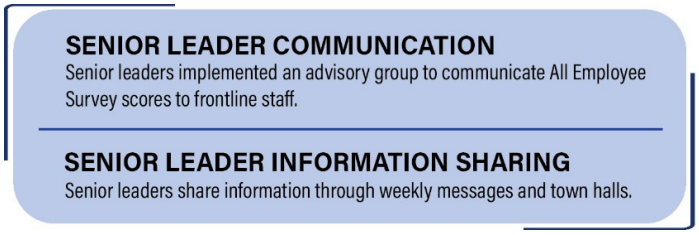


Figure 5. *Leader communication with staff.*
Source: OIG analysis of interview with facility leaders.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[25] The facility's survey scores for communication, information sharing, and

[21] Start dates for executive leadership team: Director—interim position since June 2024; Associate Medical Center Director—permanent position since January 2022; Associate Director for Patient Care Services—permanent position since September 2024; Deputy Associate Director for Patient Care Services—acting position since November 2024; Chief of Staff—permanent position since November 2021; Deputy Chief of Staff—permanent position since April 2020; and Assistant Medical Center Director—permanent position since March 2022.

[22] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[23] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[24] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[25] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

transparency improved from FY 2022 through FY 2024, and in FY 2023, they were higher than VHA averages. In an interview, executive leaders credited the improvement to reviewing survey data during town halls. In addition, each service leader reviews the scores with staff, and together they identify the top three areas of concern and develop action plans to address them.

The executive leaders stated they use many ways to communicate information to staff, adding that it is important to identify the most effective methods. For example, leaders often include a virtual meeting option, as well as record all meetings, to ensure the maximum number of staff can participate and receive the information. They acknowledged that staff are less likely to attend meetings in person when there is a virtual option. Further, leaders said they participate in daily tiered huddles with service chiefs and conduct weekly town halls and leadership rounds to different areas of the facility to meet with frontline staff.[26] They also restructured morning report meetings to replace presentations with interactive discussions about open actions and staff accomplishments.

Leaders stated facility staff report safety concerns through VHA's Joint Patient Safety Reporting system, and the Patient Safety Manager reviews those concerns daily.[27] In addition, leaders and staff track issues through an interactive board that includes safety concerns and the status on equipment, supplies, and staffing. These boards also allow staff to give accolades to colleagues, which leaders monitor daily and announce during the weekly town halls. In the OIG-administered questionnaire, respondents largely agreed that leaders had changed how they communicate; the changes are an improvement; and the information communicated is clear, useful, and frequent.

[26] Tiered huddles, used from frontline staff to senior leaders, are brief, focused meetings used to share information, identify possible problems, address staffing levels, and allocate resources. Naseema B. Merchant et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000/.

[27] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[28] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[29] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

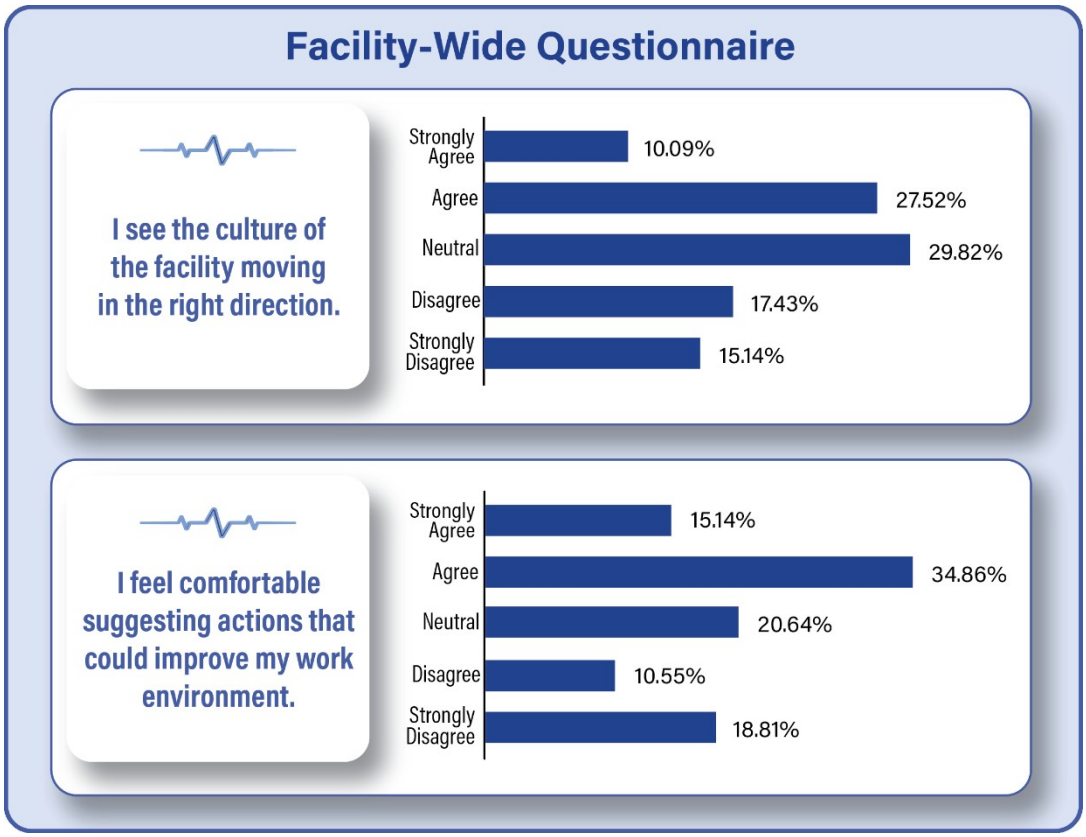


Figure 6. *Employees' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The OIG found that survey scores for best places to work, no fear of reprisal, and psychological safety improved from FY 2022 through FY 2024. In FYs 2023 and 2024, the facility outscored

[28] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[29] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

VHA averages for best places to work. In an interview, executive leaders attributed the scores to leadership rounds and open-door policies, including opportunities to "Ask the Director" any questions and email executive leaders with issues and concerns.

Results from the OIG-administered questionnaire indicated that most respondents feel comfortable reporting safety concerns and suggesting ways to improve their work environment. Moreover, the OIG noted that over a third of the respondents agreed the facility's culture is moving in the right direction. The Director explained that employees' happiness is an external factor that leaders cannot control, but what leaders can control and are obligated to do is review all patient safety reports, answer employees' questions and be consistent with responses, hold people accountable, and make sure all employees know their work matters.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[30] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[31] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In an interview, executive leaders said their interaction with VSOs decreased during and following the COVID-19 pandemic, so they plan to meet with them and hold veteran town halls in the coming months. A VSO representative who responded to the OIG-administered questionnaire reported being able to provide feedback to leaders about veterans' care, and leaders were responsive to the representative and to veterans.

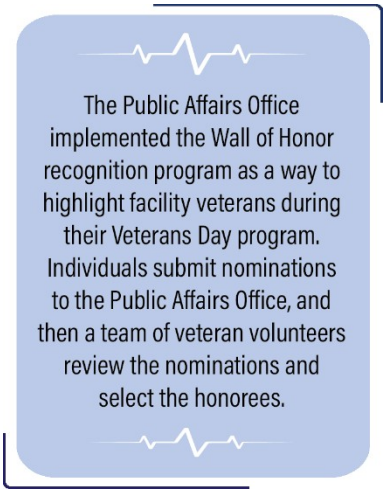


Figure 7. *Veteran Wall of Honor. Source: OIG analysis of documents.*

Leaders stated they meet daily with patient advocates to discuss veterans' concerns or complaints. In an OIG-administered questionnaire, the advocates reported the most common complaints as community care and travel reimbursement. The advocates explained that when they receive a complaint, they engage with service line leaders to resolve the problem within seven days.

[30] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[31] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[32] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 8. *Facility photo.*
Source: Photo taken by OIG inspector.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

[32] VHA Directive 1608(1).

[33] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[34] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

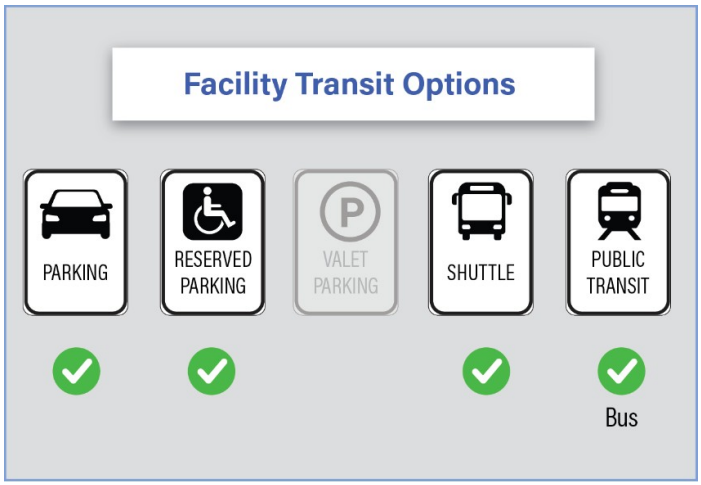


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

The OIG successfully used the address on the facility's public website to get directions to the main entrance. Posted road signs direct veterans to parking, where the lots are well-lit and have ample general spots and those accessible for people with disabilities. Shuttles transport veterans to and from the parking lots, which have call boxes to request a ride or assistance, and VA police who patrol the lots and monitor cameras. There is also a public bus stop with a sheltered waiting area directly in front of the main entrance.

Main Entrance

Figure 10. *Military memorabilia displayed at the main entrance.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[35]

The OIG noted the facility's main entrance is on one level, with an overhang that covers the passenger loading zone. Large electric sliding doors lead into a vestibule, where wheelchairs are available. At the information desk, staff direct and escort veterans to appointments as needed.

The OIG found the main entrance lobby to be spacious, clean, and bright with a mix of fluorescent and natural lighting from skylights and large windows along corridors. The lobby also has an exhibit of military service honors, including a wall-sized shadow box which contains military medals, a plaque with a tactile

[35] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

American flag and the Pledge of Allegiance written in braille, and a large display case of military uniforms from different eras and other memorabilia. In addition, the main entrance has a volunteer-run coffee bar and book exchange area with couches and chairs; and a canteen nearby.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[36]

The OIG navigated the facility following the easy-to-read signs prominently displayed on the walls. The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] The OIG noted some signs designated with the name of an area or service, as well as a pictogram. For example, a drop of blood and test tube represented the laboratory; and a box with people inside indicated an elevator.

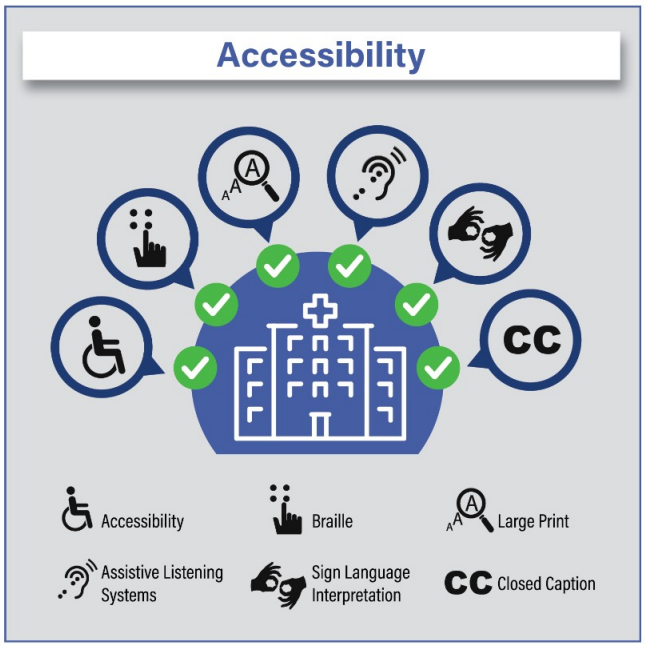


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

The OIG also observed door signs and elevator panels with braille markings, and the elevators had an audible ding when the doors opened and closed at each floor. Furthermore, the facility offers outpatient services in which staff assess veterans' needs and provide the necessary adaptive devices.

[36] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[37] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[38]

In the OIG-administered questionnaire, a toxic exposure screening navigator indicated the facility has two primary and two alternate navigators. The navigator further responded that most screenings occur during primary care and environmental health appointments, or through walk-in and virtual visits.[39] The navigators review the Unresolved Second Screening report weekly to identify patients with unresolved secondary screenings and share the list with the identified providers and their service chiefs to address.

The OIG noted an increase in the number of unresolved secondary screenings for three consecutive months in FY 2025. Due to the increase, primary care leaders stated that providers recently received training on completing toxic exposure screenings. As of February 9, 2025, the facility had no unresolved secondary screenings.

The OIG found information stands with toxic exposure flyers located throughout the facility. In January 2025, staff had screened more than 34,000 veterans, and over 14,000 reported at least one toxic exposure.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[40] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

In an interview, environment of care leaders highlighted their major barrier to environment of care maintenance as staffing and reported a vacancy rate of 20 percent. They also indicated an additional challenge as competition with community facilities to fill positions. Despite the

[38] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[39] "Environmental Health Clinicians provide specialized knowledge about potential environmental exposures and conduct exams for registry programs: Ionizing Radiation, Agent Orange, Gulf War (includes Operations Iraqi Freedom and New Dawn), and Depleted Uranium." "Public Health, Exposure Assessment," Department of Veterans Affairs, accessed July 17, 2025, https://www.publichealth.va.gov/exposure-assessment.asp.

[40] Department of Veterans Affairs, *VHA HRO Framework*.

barriers, the OIG found the facility exceeded VHA's targets for staff to resolve or develop an action plan to address work orders (deficiencies) within 14 days, and leaders to be present during quarterly environment of care rounds. The OIG did not identify any repeat findings.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected clinical and nonclinical areas throughout the facility and found the areas clean with readily accessible personal protective equipment. The OIG also noted secured medications, easily available disposal containers, and unexpired medications or supplies. The OIG found clean equipment in exam and patient rooms that had current safety inspections. The OIG also observed the community living center to be a homelike environment, where staff maintained residents' privacy, and their personal food was easily distinguishable from facility-provided food.

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG found the facility has a policy to communicate abnormal test results to ordering providers

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

[42] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

and patients; assign a surrogate (designee) when an ordering provider is unavailable or has left the facility; and communicate results outside regular clinic hours and during transitions in care. The OIG also found the local policy, dated October 2022, contained service-level workflows that describe staff member's roles in the communication process, as required by VHA.[43]

VHA requires providers to communicate abnormal test results to patients within seven days. The Chief of Staff and External Peer Review Program coordinator acknowledged staff did not always meet the requirement.[44] The Chief of Staff and quality management staff said some providers may delay communicating test results until the patient's next appointment. However, the appointment could be canceled or rescheduled, thus delaying the notification. They also said communication could be delayed if a provider is overwhelmed by the number of view alerts they receive and experience alert fatigue.[45]

The Chief of Staff and quality management staff discussed the service-level and individual provider training on how to manage view alerts to improve timeliness in communicating test results. Facility staff monitor the number of unanswered alerts, and if a provider reaches 1,000 or more, informatics staff offer the provider additional training to manage alerts and mitigate alert fatigue.

In November 2024, informatics staff added primary care nurses to the alert management system, which created a team approach to addressing view alerts. Nurses could then review alerts to check for any abnormal test results, share the information in daily team huddles, communicate the results and follow-up plans to patients under the direction of the provider, and document the exchange in the patient's electronic health record.

The Chief of Staff and quality management staff also said they implemented several processes to reduce delays in communicating test results. They mentioned that leaders recently added timely communication of test results to providers' performance evaluations for accountability and continuous improvement. Further, the External Peer Review Program coordinator initiated a process to audit the communication of test results in 2022. In primary care, the coordinator randomly selected two patient records per team per month to determine whether providers communicated test results to patients within the required time frame. The coordinator tracked the audit results and followed up with the primary care team if they did not meet the requirement; if

[43] VHA Directive 1088(1).

[44] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective actions are taken when non-compliance is identified." VHA Directive 1088(1).

[45] A view alert is an electronic notification in a computerized patient record system designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, Office of Information & Technology (OI&T), *Computerized Patient Record System (CPRS) User Guide: GUI Version,* October 2024. Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

the same team continued to fail the audit, the coordinator elevated the issue to the team's managers.

The Chief of Staff and quality management staff also discussed a pilot program to streamline communication. They implemented Clinisys software, in collaboration with the Veterans Integrated Service Network, to help providers communicate test results.[46] Clinisys is an automated program that can create test result letters which are then mailed to the patients. Staff report on communication of test results and process improvement projects to the Patient Aligned Care Team Steering Committee and the Strategic Optimization Committee.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[47] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG did not find any open recommendations from oversight reports and surveys reviewed from the past three years. The Chief of Staff and quality management staff said the current process is to monitor action plans for recommendation closure and sustained improvements. Then, staff report the status of recommendations and repeated issues to the Quality Patient Safety Board, Clinical Executive Board, and the Strategic Optimization Committee.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[48] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[49] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

[46] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/. "Accelerate Lab Innovation," Clinisys, accessed July 17. 2025, https://www.clinisys.com/us/en/.

[47] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

[48] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

[49] VHA Directive 1050.01(1).

The Chief of Staff and quality management staff said they identify patient safety concerns and opportunities for continuous improvement through audits, patient safety reports and forums, executive leaders' open office hours, committee meetings, and performance improvement boards. The Patient Safety Manager reported reviewing all Joint Patient Safety Reporting system events to identify repeat issues.

To support process improvement, the Chief of Staff and quality management staff said clinical managers provide staff with performance improvement cards to help communicate ideas. During team huddles, staff share ideas from the cards and decide whether each one is a "just do it" idea, which they implement immediately; or a "Plan-Do-Study-Act" idea, which involves a complex, formalized action plan. In an interview, the Chief Nurse of Ambulatory Care said the cards have improved processes related to test result communication and other issues across clinical settings.

The Chief of Staff and quality management staff expressed the importance of communicating process improvement initiatives to staff. They also described the culture as transparent and nonpunitive and how they embrace HRO principles to ensure patient safety.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[50] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

[50] VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[51] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

[52] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023.

The facility liaison provided documentation on the Jackson-based primary care clinic's vacancies: five provider, one registered nurse, and five medical support associate positions.[53] Leaders discussed budget constraints that began in January 2024 and limited their ability to hire, as barriers to providing care. Because of the budget constraints, leaders said they had to rescind a job offer. They also discussed a local university that discontinued its medical residency program at the facility. The loss of this program and other providers, and the hiring limitations affected veterans' access to care. Staff reported wait times of three to four months for follow-up appointments.

The leaders expressed being in the recruitment phase for the vacant provider and nursing positions; however, facility leaders had not yet approved hiring for the medical support associate positions. They added the facility had 130 vacancies in January 2025, but leaders only had approval to hire 50 staff members through FY 2025. The Chief of Staff said leaders meet regularly to discuss hiring priorities. To help ensure veterans have access to care and decrease wait times, leaders said they use float providers, who are not a part of regular primary care teams, to cover the vacant provider positions.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[54] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[55]

Staff said the principal facility coordinator position had been vacant for over a year. Leaders selected a candidate for the position but had to rescind the offer due to budget restraints. The coordinator monitors and reports on panel sizes and capacity levels, as well as ensures patients have an assigned primary care provider. The former coordinator mentioned covering the position as a collateral duty for some time and only being able to do minimal data validation, which left the OIG concerned about the accuracy of panel sizes and capacity levels. The OIG recommends the facility Director ensures staff review primary care panel sizes and capacity levels to ensure they are accurate.

Primary care staff told the OIG their panel sizes are not reasonable based on providers' required duties. Staff explained that their current panels of veterans tend to be older, with more complex needs, and require longer and more frequent appointments. To help manage patient care and maximize access, providers use clinical pharmacy visits to assist with the management of chronic

[53] The OIG did not include vacant positions at the seven community-based outpatient clinics because the contracted agencies are responsible for staffing.

[54] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[55] VHA Directive 1406(2).

diseases, such as high blood pressure and diabetes, and nursing visits to help manage some patient care needs.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[56] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care team members said they report concerns to their immediate supervisor but were unsure if their supervisors shared their concerns with executive leaders because they did not receive follow-up information. Primary care team members and leaders also identified issues regarding the inefficient use of registered nurses at the facility's call center. Team members said call center staff forward messages and requests to primary care teams to address. However, some tasks, such as medication refills and rescheduling appointments, could be handled by the call center registered nurses. The Chief Nurse of Ambulatory Care shared that one of the goals for the year is to re-educate the call center nurses on their responsibilities and scope of practice. It was unclear to the OIG if the chief nurse had shared this goal with primary care staff.

Primary care team members said process improvement ideas are implemented within their individual team; however, these ideas are not shared across primary care because each team operates differently. Executive and primary care leaders should ensure staff share information and process improvement initiatives across primary care teams and between executive leaders and staff.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found enrollment had gradually decreased from FY 2022 through FY 2024, while the number of veterans who reported toxic exposures remained stable. A primary care provider told the OIG that toxic exposure screenings have not been a significant burden. The team members described their screenings as efficient and explained that a licensed practical nurse conducts the initial screening and then informs the provider if the veteran indicates an exposure to toxins and needs a secondary screening.

[56] VHA Handbook 1101.10(2).

VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[57]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[58] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[59]

The facility's Volunteer Services operates a drive-through food pantry for veterans once a month. However, many homeless veterans lack transportation, so the HCHV Case Managers pick up food from the pantry and deliver it to them.

Figure 12. *Facility food pantry. Source: OIG interview.*

The HCHV staff consists of the program coordinator, two outreach social workers, a rural outreach social worker, and a coordinated entry specialist. The program met the HCHV5 target for FY 2023 but did not meet it in FY 2022 or FY 2024. The coordinator attributed this to the loss of an outreach social worker in December 2023, followed by an increase of walk-in homeless veterans at the facility, which limited staff's ability to conduct community outreach. The coordinator said that in June 2024, the rural outreach social worker joined the program, and they planned to hire two additional staff members.

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

[58] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[59] Local Department of Housing and Urban Development 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," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

HCHV staff explained they visit shopping centers, high traffic areas, shelters, soup kitchens, parks, hospitals, encampments, and community organizations in the service area two or three times a week to identify veterans to enroll in the program. They also said many veterans in rural areas do not consider themselves homeless because they are able to spend time in their family's home during the day but are unable to stay at night.

Additionally, staff said they participate in the point-in-time count, which occurs in late January. They consider the count to be beneficial because a decrease in the count could reflect the impact of their outreach work. Staff said they have good communication with the other homeless programs, do not work in silos, and are supported by facility leaders.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[60] The facility did not meet the HCHV1 target in FY 2022 but did meet it in FY 2023. For HCHV2, the facility met the target in FY 2023 but not in FY 2022.[61]

Program staff told the OIG that no veterans used the Harbor House program in FY 2024, so there are no available HCHV1 and HCHV2 data for that year. The program coordinator reported the facility has five contracted beds with Harbor House, a sober-living home for homeless persons with co-occurring mental health and substance use needs. Under this contract, Harbor House staff provide the mental health and substance use treatment, and HCHV staff provide case management for veterans and work with them on discharge planning. The discharge goal is for veterans to transition into either a long-term residential treatment program or permanent housing.

Staff explained the facility's Alcohol and Drug Treatment Program also contracts with Harbor House. Staff added that veterans prefer this option because they like to be around other veterans and to receive care at the facility.

The OIG found that leaders supported the program, and staff work together as a team. Staff also identified teamwork as a program strength, stating they take care of each other and the veterans. Staff said they know they make a difference because veterans express gratitude, some enrolled veterans work at the facility, and the number of homeless referrals they receive has declined.

[60] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[61] VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures.*

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[62] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[63]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[64] In an interview, the Housing and Urban Development–Veterans Affairs Supportive Housing program supervisor said the program began in 2008 with 25 housing vouchers and one case manager. Currently, the program has 482 housing vouchers and 24 staff members, including occupational therapists, nurses, case managers, peer support specialists, and substance use disorder specialists. The program has one vacancy for a supervisor. The staff emphasized their strength as being a diverse multidisciplinary team.

> To ensure safety, homeless program staff developed a "sign in and out" binder that lists the staff member's name, date, departure time, vehicle information, destination, and phone numbers. All program staff sign out before leaving the facility and sign in when they return. Staff and leaders monitor the binder to ensure all staff return to the facility as expected, and if not, they follow up to locate the staff member.

Figure 13. *Safety of homeless staff.*
Source: OIG analysis of interviews.

Despite the increased staffing, the program did not meet the HMLS3 target from FY 2022 through FY 2024.[65] The program coordinator attributed this to low housing inventory, landlords who do not accept vouchers, lack of grant money that community agencies often use to help veterans with security deposits, and lack of transportation to medical appointments. In Jackson, veterans must use vouchers within a five-mile radius of the city; however, staff said the housing options within the radius are not in the safest areas. Program staff also said they participate in events, such as the annual stand down;

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

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

[64] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[65] VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures. VHA Homeless Programs Office, Technical Manual: FY 2024 Homeless Performance Measures.*

point-in-time count; 2K walk; housing, employment, and health fairs; and town halls, to network with veterans and community partners.[66]

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[67] The program met the targets for FYs 2022, 2023, and 2024, which program staff attributed to the employment specialist's assistance in locating employment opportunities for veterans.[68]

Staff detailed being first in the Veterans Integrated Service Network to use a voucher for placing a veteran in an assisted living facility. There was one veteran housed in an assisted living facility during the time of the site visit, but staff reported placing up to three in the past. Staff said they rely on community partners to assist with financial resources for deposits, overdue rental payments, and purchases of household items and furnishings. In one example, staff explained the Progressive insurance company partners with the facility to give away a car annually to a homeless veteran. Staff said the company has provided eight cars over the years, and the giveaway was life-changing for the veterans who gained reliable transportation to get to work, family visits, and medical appointments.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[69] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[70]

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[66] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with a longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to housing and treatment services, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[67] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

[68] VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures.* VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures.*

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

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

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[71] The facility met the target for FYs 2023 and 2024. The program has three staff members, a Healthcare for Re-Entry Veterans Specialist and two Veterans Justice Outreach Specialists, and is in the process of hiring an additional staff member. The re-entry specialist works with veterans at federal and state prisons who have six months or less of their sentence remaining; connects veterans to VA and community services; and assists with locating housing, as needed, upon re-entry into society. The outreach specialists respond to referrals from facility staff, community services, and veterans and their families looking for legal help. One outreach specialist said veterans often refer each other to the program. The outreach specialists also participate in the state's two veterans treatment courts by arranging for VA care and providing treatment updates to the courts, attorneys, judges, and jail staff.[72] In addition, program staff and VA police work with local police through a deflection program, which diverts veterans away from jail to mental health or substance use treatment instead. The staff identified their strengths as commitment to teamwork, communication, and leadership support.

Meeting Veteran Needs

Program staff participate in community activities as well as provide outreach and education about the program to both facility staff and community agencies. For example, staff said the facility has a partnership with the Mississippi College School of Law to provide free legal services to veterans. In addition, staff said a veterans' benefits representative accompanies them to jails and prisons to answer veterans' questions and help them apply for VA benefits. Staff shared a success story in which an incarcerated veteran met with the veterans' benefit representative to apply for VA benefits. After receiving approval for benefits, the veteran used the income to pay for their child's dental school tuition.

[71] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[72] "Veterans Treatment Court is a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially-supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided a recommendation on issues related to the accuracy of primary care data. Recommendations do not reflect the overall quality of all services delivered within the facility. However, 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.

OIG Recommendations and VA Responses

Recommendation 1

The facility Director ensures staff review primary care panel sizes and capacity levels to ensure they are accurate.

_X_ Concur

____ Nonconcur

Target date for completion: August 2025

Director Comments

The Medical Center Director will ensure primary care panel sizes and capacity levels are reviewed and accurate in accordance with VHA standards. As of February 2025, Primary Care Leadership with oversight provided by the Chief of Staff has implemented a sustainable review process and enhanced oversight of the Patient Centered Management Module (PCCM) data report metrics to ensure Primary Care panel sizes and capacity levels remain accurate.

Key actions include reassignment of Primary Care administrative staff duties to support the PCMM coordinator enabling greater focus on data validation and weekly reviews of Patient Aligned Care Team (PACT) staffing levels, individual panel sizes, capacity, and appointment grids in collaboration with the facility Group Practice Manager (GPM) and Primary Care Leadership. This process ensures timely identification of staffing gaps, accurate provider-to-Veteran assignments, and data-driven capacity management across all Primary Care sites.

The PCMM capacity report that includes panel sizes, assignments, and staffing data is disseminated every week for review to relevant clinical and administrative stakeholders, including Executive Leadership. The weekly PCMM reports are compiled, summarized, and reviewed at the monthly Primary Care PACT Steering Committee, which reports quarterly to the Healthcare Delivery Council (HDC). In addition, the information is reviewed quarterly in the Strategic Optimization Committee, which is chaired by the Medical Center Director.

Based on the corrective actions taken and the ongoing monitoring process in place, the facility requests closure of this recommendation at the time of publication.

OIG Comments

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

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to two VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from January 13 through 16, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issues.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2022, through September 30, 2024.

[2] The OIG received responses from two VSOs (Hinds County Board of Supervisor County Veterans' Services Office and Mississippi Veterans Affairs Board).

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

[4] 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] 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.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 15, 2025

From: Interim Network Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Facility Inspection of the VA Jackson Healthcare System in Mississippi

To: Director, Office of Healthcare Inspections (54HF02)

Director, GAO/OIG Accountability Liaison (10OIC GOAL)

1. The South Central VA Health Care Network (10N16) has reviewed and concurs with the facility's response to the one (1) recommendation contained in the draft report of the Healthcare Facility Inspection of the VA Jackson Healthcare System in Mississippi.

   (Original signed by:)

   Fernando O. Rivera, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 11, 2025

From: Director, VA Jackson Healthcare System

Subj: Healthcare Facility Inspection of the VA Jackson Healthcare System in Mississippi

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft report from the OIG Healthcare Facility Inspection of the Jackson VA Healthcare System. I concur with the recommendation contained in the report.
2. A corrective action plan has been implemented as detailed in the attached report.
3. If you have additional questions, please contact the Chief of Quality, Safety, and Improvement.

(Original signed by:)

Michael Renfrow
Executive Director

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