US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery

Healthcare Facility Inspection	24-03419-34	January 28, 2026

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Executive Summary

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG examined the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families. The OIG continued communication with VHA regarding the findings of this inspection, which resulted in the closure of one recommendation.

What the OIG Found

The OIG physically inspected the VA Central Alabama Health Care System (facility) from November 19 through 21, 2024.[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. Executive leaders identified an active threat incident in September 2024, and VHA staffing budget changes in fiscal year 2024 as two system shocks that affected the facility, veterans, and staff.[2]

During the active threat incident, VA Police and local law enforcement collaborated to ensure everyone's safety. After the incident, executive leaders met with staff and provided resources to help them process the incident. In response to staff concerns and ideas, executive leaders developed a workgroup to implement suggestions such as establishing safe locations in case of similar future situations.

To address the budget changes, the Chief of Staff reported the facility's Resource Executive Council reviewed staffing needs and prioritized hiring. Leaders had rescinded job offers due to

[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.

[2] Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024.

the restrictions, and the council reevaluated these decisions and approved some of the nursing position selections. Leaders said they reviewed workload and productivity, and had open dialogues with veterans to help them understand the hiring situation. Leaders further discussed general recruitment challenges, such as the shared belief that a lack of academic affiliations makes it difficult to attract applicants. The OIG also noted difficulties in recruiting radiologists, with six of seven positions vacant. However, the leaders explained they had just selected a candidate for the chief of radiology position and used services from a national VHA teleradiology program and another VHA facility for assistance.

The OIG found responses to the All Employee Survey for fiscal years 2021 through 2024 were similar to VHA averages for senior leader communication and information sharing.[3] For no fear of reprisal and workgroup psychological safety, results during those same years remained below VHA averages.[4] Executive leaders shared efforts to build relationships, have open discussions with employees, and empower service leaders to confidently make decisions.

Additionally, the OIG surveyed facility patient advocates and found veterans expressed concerns about travel reimbursements. The Associate Director acknowledged the issue and shared a belief that a recent change in the reimbursement process from paper to an electronic system was a contributing factor, noting a need for more veteran education.

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.

The OIG found the facility had multiple options available to assist individuals with sensory impairments; however, it lacked certain resources. For example, common area televisions at both facility's medical centers did not always have closed captions in use. Additionally, the OIG observed multiple crosswalks at one medical center without detectable warning surfaces, which alert pedestrians with visual impairments of potential hazards where the sidewalk transitions onto the roadway. The OIG made a recommendation. In response, the Director reported staff ordered multiple detectable warning surfaces and repaired a damaged one.

[3] 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.

[4] "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.

The OIG also evaluated aspects of the toxic exposure screening process. The OIG learned multiple staff had not completed the training required to conduct the screenings, although the Associate Chief of Staff for Ambulatory Care explained providers had completed other training. The OIG made a recommendation to address training requirements. The Director stated most staff completed the required training as of October 2025, and all new clinical providers would receive the training.

The OIG also found the facility had over 1,000 incomplete toxic exposure screenings. The Associate Chief of Staff for Ambulatory Care explained the screening is a two-part process, and when clinical staff initiate a screening but do not complete it, they must contact the patients for follow-up. Facility leaders should identify additional barriers to staff completing the toxic exposure screenings at the time of the patient visit and implement corrective actions to ensure staff complete screenings timely.

During the physical inspection, the OIG observed dusty sprinkler heads at one medical center, which is the same deficiency found in a prior oversight report. This repeat finding indicates staff did not sustain improvement actions, and therefore, the OIG made a recommendation. As a result, the Director explained that staff will regularly inspect sprinkler heads.

Additionally, the OIG identified areas that lacked a safe and functional environment. For example, the OIG identified a potential infection risk where staff stored clean equipment in a biohazard room. The OIG also observed stained ceiling tiles, soiled floors, and holes in the walls. The Acting Chief of Environmental Management Service explained that environmental management recruitment had been on hold due to a lack of funding; there were 13 staff vacancies, 4 of which were supervisory positions. The OIG recommended leaders evaluate the environment and address these issues. The Director stated staff will monitor biohazardous material storage areas and leaders are addressing staffing issues.

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 found staff had developed a facility policy for test result communication but lacked service-level workflows to identify providers and staff who can communicate patient test results as required by VHA.[5] The policy referenced an outdated version of the VHA directive and did not identify the person responsible for monitoring the effectiveness of their processes for communicating test results to patients. The OIG made a recommendation.

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

In response, the Director reported staff drafted a standard operating procedure that includes service level workflows, and it is undergoing final review.

VHA requires facility leaders to address deficiencies in providers' test result communication.[6] The OIG found the communication of test result data trended downward for the first three quarters of fiscal year 2024, although they improved in the last quarter. While leaders reported reviewing the data, they could not describe any actions taken to improve performance. The OIG recommended the Chief of Staff and Associate Director for Patient Care Services ensure corrective actions address unfavorable trends in the communication of test result data. The Director explained that a workgroup created an action plan to address the issues.

Additionally, the OIG reviewed selected peer reviews with the corresponding committee meeting minutes and found the Chief of Staff attended one of six meetings, described as due to scheduling conflicts.[7] VHA requires the Chief of Staff to chair and attend peer review committee meetings, and therefore, the OIG made a recommendation. The Director described rescheduling the meeting to ensure the Chief of Staff could attend.

The OIG also reviewed the facility's adverse events and found patient safety staff did not identify two incidents that met sentinel event criteria and determined one of these events also warranted an institutional disclosure.[8] The OIG made associated recommendations. In response, the Director stated the Clinical Review Group meets weekly to review adverse events and evaluate whether they meet sentinel event and institutional disclosure criteria.

The OIG was told about staff's response to an emergency medical event and found that staff had not completed all identified actions for improvement, and not all clinical staff had current basic life support certification. The OIG made several recommendations to address these deficiencies. The Director reported that staff update the Quality and Patient Safety Council on the status of overdue actions monthly, nurses trained staff on emergency responses, and clinical staff are receiving basic life safety training.

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[6] VHA Directive 1088(1).

[7] A peer review is a "critical review of care performed by a peer" to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[8] "Sentinel events are a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of the duration of harm), or permanent harm (regardless of severity of harm)."The Joint Commission, *Comprehensive Accreditation Manual for Hospitals, Sentinel Event Policy (SE)*, July 2024. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a "formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." VHA Directive 1004.08.

Additionally, the OIG found leaders had not revised the facility's emergency response policy since 2014 and made a related recommendation. The Director explained leaders approved the facility's standard operating procedure in October 2025, and staff are receiving education about it.

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 primary care delivery structure and new patient appointment wait times.[9]

Staff and leaders stated the biggest challenge for primary care was staffing. The OIG noted only 29 of the facility's 45 primary care teams were fully staffed, and 30 exceeded VHA's recommended panel sizes (the number of patients assigned to each team). However, staff members stated they feel supported by leaders, and leaders expressed a desire to add more teams in the next year. The facility had a slight increase in veteran enrollment since fiscal year 2022, and new patient appointment wait times were approximately 33 days, which exceeds VHA recommendations.[10] The OIG made a recommendation for panel size management. In response, the Director stated leaders increased staffing, reassigned patients, and reviewed overcapacity teams.

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. The Health Care for Homeless Veterans program did not meet VHA targets for engagement, permanent housing, and negative exits.[11] Staff explained staffing vacancies limited outreach efforts and added that these programs covered a large geographical region, which included some rural areas in two states, as another barrier.

The Veterans Justice Program exceeded VHA targets for veterans entering the program in fiscal year 2023, and they were working toward meeting targets for fiscal year 2024. Staff described conducting outreach at jails, prisons, courts, and community partner sites to identify individuals

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

[10] VHA expects primary care clinic wait times to be 20 calendar days or less. VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

[11] Negative exits refer to 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). VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

who may be eligible for services. Staff attributed their success in part to establishing trust with veterans and helping them meet goals.

What the OIG Recommended

The OIG made 15 recommendations.

1. Facility leaders install detectable warning surfaces where crosswalks transition onto a vehicle roadway.
2. Facility leaders ensure clinical staff who perform toxic exposure screenings complete mandatory training.
3. The Director ensures staff implement processes to prevent repeat environment of care findings related to dusty sprinkler heads.
4. Facility leaders evaluate all areas where biohazardous materials are located to ensure staff store clean and dirty items separately.
5. The Director ensures staff keep the environment clean and safe.
6. Facility leaders ensure their policy aligns with VHA Directive 1088(1) and develop workflows for all services that communicate test results to patients.
7. The Chief of Staff and Associate Director for Patient Care Services ensure corrective actions address unfavorable trends in communication of test result data.
8. The Director ensures the Chief of Staff chairs and attends the Peer Review Committee meetings as required by VHA.
9. The Director ensures patient safety managers identify adverse events as sentinel events when they meet criteria.
10. Facility leaders evaluate and improve processes to identify adverse events that warrant an institutional disclosure.
11. The Director implements processes to ensure staff track action plans until they are completed and report to leaders those that are outstanding.
12. The Director ensures leaders train staff on their roles and responsibilities when responding to a medical emergency, including the location of equipment used for medical emergencies.
13. The Director ensures leaders revise the emergency response policy based on recertification time frames in VHA Directive 0999(1) or sooner, if warranted.
14. Facility leaders ensure all applicable staff maintain basic life support certification and take appropriate action for those staff without it.

15. The Director ensures facility leaders manage primary care teams' panel sizes to support patients' access to care.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans (see OIG Recommendations and VA Responses, and appendixes D and E for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 12 closed. For the remaining open recommendations, leaders are implementing corrective actions, and the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
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

FACILITY IN CONTEXT

VA Central Alabama Health Care System
Montgomery, Alabama
Level 2-Medium Complexity
Montgomery County
Hospital Referral Region: Montgomery

Description of Community

POPULATION

Female **386,661**	Male **356,759**
Veteran Female **10,060**	Veteran Male **54,080**

Homeless - State **3,752**
Homeless Veteran - State **308**

MEDIAN INCOME

$44,736

EDUCATION

84% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **465**

SUBSTANCE USE

29.7% Driving Deaths Involving Alcohol
14.5% Excessive Drinking
84 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	261,202
Carpool	26,555
Work at Home	11,593
Walk to Work	4,538
Other Means	3,046
Public Transportation	804

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**33 Minutes, 28 Miles**
Specialty Care	**56 Minutes, 49.5 Miles**
Tertiary Care	**130.5 Minutes, 137.5 Miles**

Access to Health Care

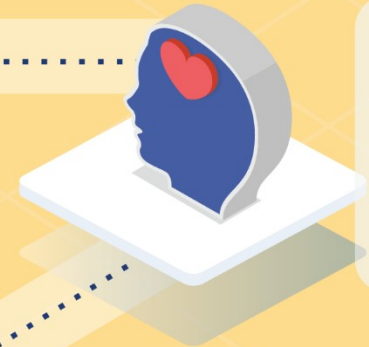
ACCESS

VA Medical Center Telehealth Patients **18,009**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	38%
<65 without Health Insurance	14%

Health of the Veteran Population

64 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

17,469

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.18 Days

30-DAY READMISSION RATE

10%

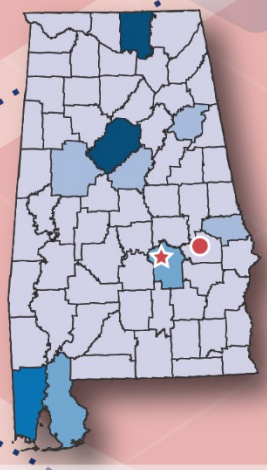
SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
20	35

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	55K
Unique Patients VA Care	53K
Unique Patients Non-VA Care	33K



- Central Alabama VA Medical Center-Montgomery
- Central Alabama VA Medical Center-Tuskegee

The VA Central Alabama Health Care System includes the Central Alabama VA Medical Center-Montgomery and the Central Alabama VA Medical Center-Tuskegee.

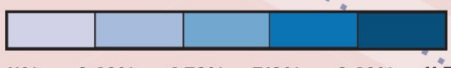
COMMUNITY CARE COSTS

Unique Patient $12,320	Outpatient Visit $264
Line Item $300	Bed Day of Care $336

STAFF RETENTION

Onboard Employees Stay <1 Yr	13.67%
Facility Total Loss Rate	14.84%
Facility Retire Rate	3.31%
Facility Quit Rate	10.19%
Facility Termination Rate	1.04%

VETERAN POPULATION



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) 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 program to 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 (VA), "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]

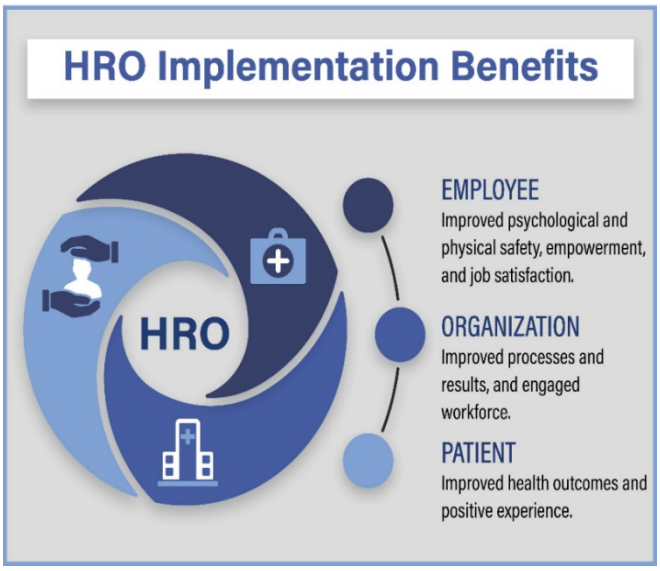


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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

[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.

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 Central Alabama Health Care System (facility) was established in 1997, through the merger of the Montgomery VA Medical Center, which opened in 1940, and the Tuskegee VA Medical Center, which opened in 1923.[13] The Acting Deputy Director reported the facility's fiscal year (FY) 2024 budget as approximately $711,000,000. The Associate Director for Patient Care Services (ADPCS) stated the Central Alabama VA Medical Center–Montgomery (Montgomery VA Medical Center) had 30 inpatient medical surgical beds; and the Central Alabama VA Medical Center–Tuskegee (Tuskegee VA Medical Center) had 196 beds, including community living center, inpatient mental health, and domiciliary beds.[14] The most recent major renovations occurred in 2017 at the Montgomery VA Medical Center's emergency department and Tuskegee VA Medical Center's dental and podiatry clinics.

In November 2024, the Deputy Chief of Quality Management reported the facility's executive leaders consisted of the Acting Health Care System Director (Acting Director), Acting Deputy Director, Associate Director, Assistant Director, ADPCS, and Chief of Staff. The newest member of the leadership team was the Associate Director, assigned in September 2024. The Acting Director, who was assigned to the Deputy Director position in December 2017, was the most tenured. The Deputy Director served in the acting director role since January 2024, while the Director was detailed to Veterans Integrated Service Network (VISN) 19.[15]

[13] Under the merger, the facility's medical center names are Central Alabama VA Medical Center–Montgomery, formerly the Montgomery VA Medical Center, and the Central Alabama VA Medical Center–Tuskegee, formerly the Tuskegee VA Medical Center. "About Us," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/central-alabama/about-us/. "History," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/central-alabama/history/.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/VA_CLC. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/homeless/dchv.asp.

[15] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Services Network (VISN)," Department of Veterans Affairs, accessed December 2, 2024, https://www.va.gov/HEALTH/visns.asp.

A 2018 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."[16] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[17] 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 facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[18]

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.[19] 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.[20] 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.

Executive leaders shared two system shocks: an active threat incident in September 2024, and VHA staffing budget changes initiated in FY 2024.[21] The executive leaders described the active threat incident, which began with a phone call from a veteran communicating intent to harm staff at the Montgomery VA Medical Center. The Acting Director said local law enforcement worked

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

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

[18] 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.

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

[20] 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*.

[21] Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024.

with VA Police to secure the facility and a school located across the street; subsequently, authorities identified and arrested the suspect at another location. The Acting Director explained that because the media at first erroneously reported the incident as an active shooter event, family members made multiple phone calls to the facility attempting to contact their loved ones. The media corrected the initial report shortly thereafter.

Executive leaders conducted a virtual town hall with staff immediately after the incident to discuss actions taken by leaders and police, solicit their feedback, provide information about support resources, and answer questions. The ADPCS further shared that leaders implemented a workgroup to review staff's suggestions and lessons learned, such as establishing safe locations in each area in case a similar incident happens again. The ADPCS reported leaders also coordinated with the Veterans Crisis Line and facility mental health team to identify potentially missed opportunities in the veteran's evaluation.

Regarding the second system shock, the Chief of Staff stated leaders rescinded employment offers to some individuals because of VHA budget changes to reduce overall staffing levels. They also implemented a Resource Executive Council to organize and review staffing needs and establish priorities for hiring. For example, after reevaluation, the council approved hiring for some nursing positions in which the previously selected candidates had offers rescinded. The Chief of Staff also discussed how staff maintained open dialogue with veterans to help them understand that staffing was being restructured and hiring had not stopped.

Leaders acknowledged that even prior to the staffing budget changes, they experienced challenges filling some vacancies due to limited academic affiliations and technical training programs available in the area. The Acting Deputy Director said efforts to find qualified staff included collaborating with colleagues in the community for referrals and using contracts for specialized, hard-to-fill positions such as boiler plant operators. The Chief of Staff elaborated on the staffing challenges and shared that shortly after accepting the position, the Deputy Chief of Staff was assigned to cover multiple roles, including as the Acting Chief of Radiology and Acting Chief of Informatics.[22]

During an interview, the OIG learned of additional staffing challenges, specifically within the radiology service. The Radiology Supervisor reported six of seven radiologist positions were vacant. The Deputy Chief of Staff stated the chief of radiology position had been vacant since approximately June 2021, but they had recently selected a candidate and hired two part-time radiology providers. To cover for the vacancies, facility leaders used services from the VHA National Teleradiology Program and the Ralph H. Johnson VA Medical Center in

[22] The Deputy Chief of Staff was a primary care provider.

Charleston, South Carolina, and noted there were no delays with the communication of results to providers and patients.[23]

The Deputy Chief of Staff also reported the chief of informatics position had been vacant approximately eight years, with multiple leaders serving in the acting role, and it was challenging to compete with community pay for equivalent positions. The Chief of Staff said they received approval to hire for the position in August 2023 and planned to request a 120-day staff assignment from VISN leaders while they continued to recruit.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[24] 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.[25] 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."[26] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[27]

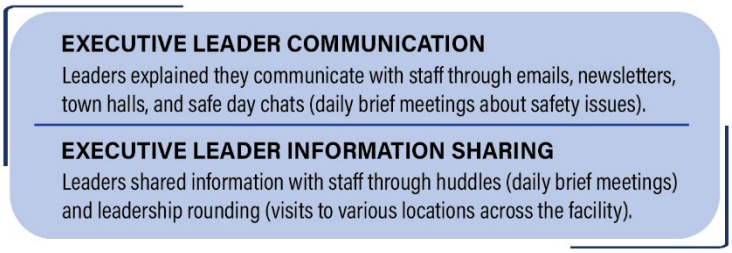


Figure 4. *Leader communication with staff.*
Source: OIG analysis of All Employee Survey data and interviews with facility leaders.

The OIG found the survey results for senior leader communication and information sharing were similar to VHA averages in FYs 2021 through 2024. Acknowledging the survey results,

[23] "NTP [the National Teleradiology Program] provides 24/7 diagnostic radiology services to Department of Veterans Affairs (VA) medical facilities located in all Veterans Integrated Service Networks (VISNs), rendering final diagnostic interpretations on a wide variety of modalities including computerized tomography scans (CTs), X-rays, magnetic resonance imaging (MRI), ultrasound, and nuclear medicine imaging studies." VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

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

[25] 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*.

[26] 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.

[27] 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.

executive leaders said they ensured that facility leaders display survey data in the staff work areas to help them gather ideas for improvement from the staff.

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.

The OIG noted that survey results for workgroup psychological safety and no fear of reprisal remained below VHA averages for FYs 2021 through 2024, suggesting that employees were less comfortable in these areas than VHA employees in general. The Chief of Staff shared an example that after taking the position in July 2022, respondents who reported to the Chief of Staff produced the lowest survey scores in the facility. The leader described strategies taken to improve survey scores, such as building relationships with service leaders through open discussions and decision-making support.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[30] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

The OIG found that patient advocates identified travel pay reimbursement as veterans' most reported complaint. The Associate Director explained the reimbursement process had transitioned from paper to an electronic system and many veterans preferred the former process, and acknowledged the need to further educate veterans on the new system.

[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.

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

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.[31] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way), 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 5. *Central Alabama VA Medical Center–Montgomery (left); Central Alabama VA Medical Center–Tuskegee (right).*
Source: "VA Central Alabama Health Care," Department of Veterans Affairs, accessed October 22, 2024, https://www.va.gov/central-alabama-health-care/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[32] 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

[31] VHA Directive 1608(1).

[32] 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.

evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[33]

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.

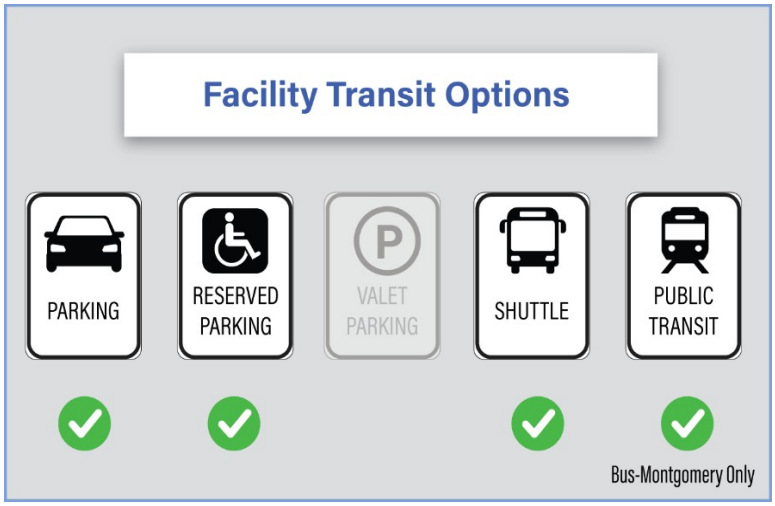


Figure 6. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG inspection team used a commercial navigation application to travel to the facility's two medical centers and found the instructions easy to follow. At each medical center, the OIG noted exterior signs directing veterans to parking and building locations; however, many signs were faded, worn, and lacked lighting (see appendix C). Because facility leaders said they plan to update all exterior and interior signs at both locations starting in January 2025, the OIG did not make a recommendation.

Main Entrance

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.[34]

The OIG noted the main entrance to both medical centers had passenger loading zones, power-assisted doors, and available wheelchairs. Additionally, the OIG found the lobbies generally clean and well-lit, with seating areas and information desks. An information desk employee told the OIG that employees or volunteers staffed the information desk at the Montgomery VA Medical Center weekdays during business hours, whereas volunteers operated the Tuskegee VA

[33] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, 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.

[34] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Guide*.

Medical Center information desk as their schedules permitted.[35] At the Tuskegee VA Medical Center, the OIG observed veterans using the check-in desk across the lobby when the volunteers were not present.

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 found electronic map kiosks located near both main entrances, where veterans could print turn-by-turn directions or download an electronic map to a personal device. In addition, the OIG used existing cues, such as wall directories, to navigate the medical centers.

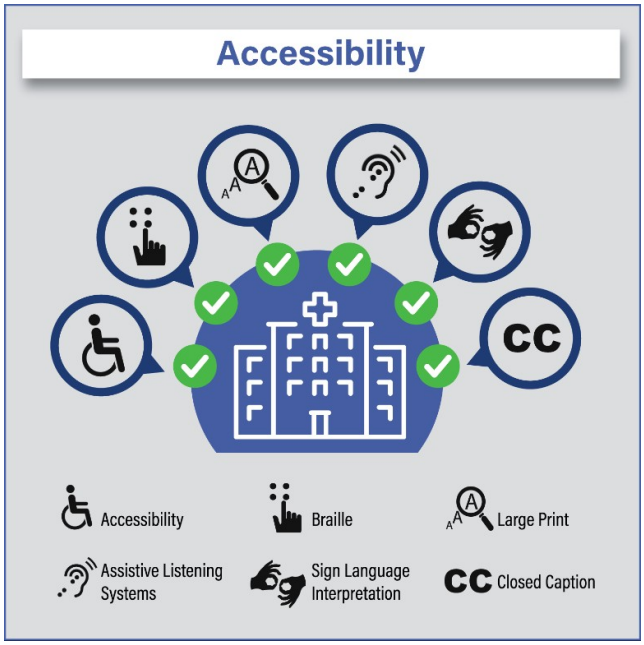


Figure 7. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] At the Tuskegee VA Medical Center, the OIG observed multiple crosswalks that lacked detectible warning surfaces, which VA's *Site Design Manual* requires to alert visually impaired pedestrians of potential hazards before they transition onto a roadway.[38] The OIG recommended facility leaders install detectable warning surfaces where crosswalks transition onto a vehicle roadway. In response, the Director stated staff assessed sidewalks, ordered multiple

[35] The information desk at the Montgomery VA Medical Center was staffed 7:30 a.m. to 4:00 p.m. Monday through Friday.

[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.

[38] VA Manual PG 18-10, *Site Design Manual*, February 1, 2013, revised March 1, 2024.

detectable warning surfaces, and replaced one damaged surface (see OIG Recommendations and VA Responses).

During the inspection, the OIG found multiple accessibility features, such as electronic maps with zoom-in capability, to assist individuals with visual impairments navigate the medical centers. Additionally, staff reported they escort those individuals to their desired location, if needed.

Staff said they communicate in writing with individuals with hearing impairments. However, the OIG observed televisions in multiple public waiting rooms at both locations that did not use closed captioning. Facility leaders should use closed captioning on televisions in common areas.

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.[39]

A toxic exposure screening navigator said the facility had two navigators, and this responsibility was in addition to their other primary duties. VHA guidelines specify that clinical staff who have completed required toxic exposure training perform initial screenings, and only those who are authorized closers complete the follow-up part of the screening.[40] The OIG found there were 20 clinical staff who had not completed the required training, which may have resulted in them screening veterans without knowledge of the process and expectations. Although the Associate Chief of Staff for Ambulatory Care said staff had completed other trainings, the OIG is concerned they did not complete the required training. The OIG recommended facility leaders ensure clinical staff who perform toxic exposure screenings complete mandatory training. In response, the Director reported staff had a 98.6 percent compliance rate for completing the required training as of October 2025, and all new clinical providers were assigned the training (see OIG Recommendations and VA Responses).

Additionally, the OIG reviewed toxic exposure screening progress reports and found staff had not completed over 1,000 follow-up screenings. The Associate Chief of Staff for Ambulatory

[39] 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.

[40] Authorized closers include privileged clinical staff such as medical doctors, doctors of osteopathic medicine, advanced practice registered nurses, physician assistants, and registered nurses who are permitted to enter consults and add diagnoses to the veteran's problem lists in the medical record. "Toxic Exposure Screening Frequently Asked Questions," VHA War Related Illness and Injury Study Center, accessed November 14, 2024, https://dvagov.sharepoint.com//ToxicExposureScreeningFAQ.aspx. (This site is not publicly accessible.) Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (11), "For Action: PACT Act Section 603, Toxic Exposure Screening Training for all Veterans Health Administration (VHA) Providers (VIEWS 10873788)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), September 27, 2023.

Care explained there were 7,000 incomplete screenings in June 2023, and staff had since reduced the backlog. The associate chief identified a challenge that occurs when clinical staff initiate a screening, but a clinical staff member who is an authorized closer does not complete it during the same visit; staff must then take additional time to contact the patient to complete it. A January 2025 toxic exposure screening document says authorized closers must complete the screening "as soon as feasible, in not more than 30 days."[41] Facility leaders should identify additional barriers to staff completing the toxic exposure screenings at the time of the patient visit and implement corrective actions to ensure staff complete screenings timely.

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.[42]

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.

VHA Directive 1608(1) requires facilities to adhere to regulatory and accrediting bodies' requirements and ensure the healthcare environment is safe and clean.[43] The OIG reviewed an April 2022 Joint Commission accreditation report that included findings of dust on sprinkler heads at the Montgomery VA Medical Center, which staff had corrected while The Joint Commission was on-site.[44] However, the OIG observed the same deficiency in both clinical and nonclinical areas, which indicates staff had not sustained the improvement actions. The Assistant Director explained the Montgomery VA Medical Center did not have a schedule for cleaning sprinkler heads and acknowledged a lack of supervisory oversight. The OIG recommended the Director ensures staff implement processes to prevent repeat environment of care findings related to dusty sprinkler heads. The Director explained that staff will check sprinkler heads during Comprehensive Environment of Care rounds and monthly fire extinguisher inspections (see OIG Recommendations and VA Responses).

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[41] VA OIG, *Veterans Health Administration Initiated Toxic Exposure Screening as Required by the Promise to Address Comprehensive Toxics (PACT) Act but Improvements Needed in the Training Process*, Report No. 23-02682-09, November 14, 2024; "Toxic Exposure Screening Process For Staff Use," Department of Veterans Affairs, updated January 2025, https://dvagov.sharepoint.com/sites/vawriisc/TESToolkit. (This website is not publicly accessible.)

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

[43] VHA Directive 1608(1).

[44] The Joint Commission performed hospital, behavioral health and human services, and home care accreditation inspections in April 2022. The Joint Commission, *Final Accreditation Report: Central Alabama Veterans Health Care System*, April 28, 2022. (This report is not publicly accessible.)

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 several clinical areas and found no privacy concerns or medical equipment preventative maintenance deficiencies. However, the OIG observed an area where staff stored clean oxygen tanks in soiled utility rooms containing biohazardous materials, which may pose an infection risk.[45] The OIG recommended facility leaders evaluate all areas where biohazardous materials are located to ensure staff store clean and dirty items separately. In response, the Director stated staff will monitor biohazardous material storage areas and leaders are reviewing a standard operating procedure for oxygen storage (see OIG Recommendations and VA Responses).

The OIG observed stained ceiling tiles, damaged or rusted ceiling vents, and holes in the walls throughout both locations.[46] The OIG also noted soiled floors in multiple areas, including patient care rooms, bathrooms, biohazard rooms, and stairwells.

Leaders attributed the deficiencies to position vacancies, and the engineering service's reliance on frontline staff to notify them of needed repairs so they could fix them. The Acting Chief of Environmental Management Service reported 13 vacancies, 4 of which were supervisory positions. The acting chief added that recruitment had been on hold due to a lack of funding, but leaders recently resumed hiring for the positions. The OIG recommended the Director ensures staff keep the environment clean and safe. The Director reported leaders are currently recruiting for Environment Management Service positions and drafting standard operating procedures for the service (see OIG Recommendations and VA Responses).

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.

[45] VHA expects facilities to have guidelines for staff to separate contaminated from clean supplies. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

[46] According to Joint Commission, a hospital "establishes and maintains a safe, functional environment." The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, August 1, 2024.

Communication of Urgent, Noncritical Test Results

VHA Directive 1088(1) 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.[47] 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.[48] 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.

VHA requires facility staff to develop a policy for communicating test results to providers and patients.[49] While the OIG found facility staff developed a policy for test result communication, it did not align with the current VHA directive.[50] For example, the facility policy referenced an outdated version of the VHA directive. It also did not identify how to monitor the effectiveness of their processes for communicating test results to patients. Executive leaders acknowledged the policy was missing elements and indicated they were revising it. The ADPCS shared that since their policy had not expired, staff did not compare it to the updated directive.

VHA also requires the chief of staff and ADPCS to ensure staff develop service-level workflows that identify all providers and staff who can communicate test results to patients.[51] The OIG reviewed a pathology and laboratory policy that contained a workflow process for communicating only critical results, but not noncritical results. The OIG also reviewed a primary care standard operating procedure outlining the types of laboratory test results providers and nurses could communicate to patients; however, it did not include radiology test results.

The OIG did not receive workflows from any other services. Executive leaders acknowledged they lacked service-level workflows, but the ADPCS said primary care nurses had a written process for communicating laboratory test results to patients. The OIG recommended facility leaders ensure their policy aligns with VHA Directive 1088(1) and develop workflows for all services that communicate test results to patients. As a result, the Director stated staff drafted a standard operating procedure, including service level workflows, and it is in final review (see OIG Recommendations and VA Responses).

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

[48] 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.

[49] VHA Directive 1088(1).

[50] Central Alabama Veterans Health Care System Memorandum, No. 11-21-33, *Communicating Test Results to Providers and Patients,* November 19, 2021; VHA Directive 1088(1).

[51] VHA Directive 1088(1).

Additionally, VHA requires the director to ensure staff review data related to communication of test results and address any deficiencies.[52] Further, VHA requires the chief of staff and ADPCS to make certain that staff take corrective action when they identify noncompliance.[53] The OIG reviewed the facility's FY 2024 communication of test result data and found a downward trend for the first three quarters, which indicated performance results were getting worse, although results improved in the final quarter.[54]

When the OIG asked executive leaders if they were aware of the downward trend and what actions they had taken for improvement, they reported discussing data during several executive leadership committee meetings but were not aware of the trend for these data. Further, the Deputy Chief, Quality Management stated staff review test result communication data at the monthly Performance Improvement Committee; however, the committee had not requested follow-up from staff on actions to improve performance. The OIG recommended the Chief of Staff and ADPCS ensure corrective actions address unfavorable trends in communication of test result data. The Director explained that a workgroup developed an action plan to address communication issues and will report progress monthly to the Performance Improvement Committee (see OIG Recommendations and VA Responses).

The Associate Chief of Staff for Ambulatory Care reported monitoring providers' test result communication through Ongoing Professional Practice Evaluations; a provider found to be delinquent with this requirement could undergo a Focused Professional Practice Evaluation for Cause review.[55] However, the OIG is concerned that relying solely on Ongoing Professional Practice Evaluations, a process which includes a small sample of electronic health records to review, limits facility leaders' ability to identify trends in test result communication. Although staff monitored some data, leaders should evaluate the monitoring process and improve it, if needed.

[52] VHA Directive 1088(1).

[53] VHA Directive 1088(1).

[54] CTR [communication of test result] 24 is a metric that identifies "the percent of outpatient tests with Abnormal results" requiring action that staff communicate to patients within seven days "from the time the test result is available." CTR 25 identifies "the percent of outpatient Abnormal Test Results" requiring action that staff communicate "within 30 days from the time the test result is available." "Electronic Technical Manual (eTM) Measure Library" (website), VA Office of Quality and Patient Safety Performance Measurement, http://pm.rtp.med.va.gov//PerformanceReportsMeasureCatalog. (This website is not publicly accessible.)

[55] Leaders use the Ongoing Professional Practice Evaluation process to monitor a licensed independent health care practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." A Focused Professional Practice Evaluation for Cause is a time-limited review to evaluate a provider's performance after a clinical concern has been identified to determine if additional actions should be taken. VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023.

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.[56] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

A 2024 OIG inspection report had two open recommendations related to suicide prevention screening and suicide event reporting to mental health leaders and quality management staff.[57] When the OIG asked quality management staff about the status of these action plans, the Deputy Chief, Quality Management stated staff track their progress and plan to request closure for one recommendation during the next OIG update and will continue to monitor the other.

Continuous Learning through Process Improvement

According to the *VHA High Reliability Organization (HRO) Reference Guide*, continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[58] Further, pursuant to VHA Directive 1050.01(1), 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.[59] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

A systems redesign staff member described a process improvement initiative implemented in May 2024 to reduce delays in communicating test results to patients via mail. Staff from one outpatient clinic used an automated centralized printing system to send selected normal test results and other administrative correspondence to patients. The systems redesign staff member stated clinic employees mailed 5,485 letters to patients from May through September 2024, which increased compliance with the timely communication of test result performance metrics by 71 percent. The staff member added the goal is to incorporate this process into other areas throughout the healthcare system.

The Associate Chief of Staff for Ambulatory Care added the project reduced the amount of time for providers to send patients' results and improved efficiency. The OIG recognizes that facility

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

[57] VA OIG, Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery, Report No. 23-00106-94, March 12, 2024. As of August 2025, the two recommendations are closed.

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

[59] VHA Directive 1050.01(1).

staff have improved their process of sending result letters to patients but remains concerned about leaders' lack of processes in general to identify and follow up on communication of test result data trends, as discussed above.

As part of the continuous improvement process, the OIG analyzed peer reviews and corresponding committee meeting minutes and identified the Chief of Staff did not consistently attend these meetings.[60] VHA Directive 1190(1) requires the chief of staff to chair the Peer Review Committee, provide "clinical oversight of the Peer Review for Quality Management Program," and attend the peer review committee meetings except for occasional absences.[61] The Chief of Staff reported chairing the committee; however, the OIG found the Chief of Staff attended only one of six meetings. The Chief of Staff said the monthly Peer Review Committee meeting conflicted with another mandatory meeting with human resources staff but reported receiving information from the two Deputy Chiefs of Staff who attended the meetings to maintain accountability and oversight. The OIG recommended the Director ensures the Chief of Staff chairs and attends the Peer Review Committee meetings as required by VHA. The Director explained they rescheduled the meeting to ensure the leader could attend (see OIG Recommendations and VA Responses).

Additionally, the OIG interviewed quality management staff and reviewed patient safety events and institutional disclosures for the 12 months prior to the inspection.[62] The OIG found staff did not identify two adverse events as sentinel events and did not conduct an institutional disclosure for one of these events. While the patient safety managers acknowledged the adverse events, they said the two cases did not meet sentinel event criteria. Additionally, the risk manager did not recall why one of these adverse events was not also considered for an institutional disclosure; and the Chief of Staff reported not receiving the event for review. The OIG recommended the Director ensures patient safety managers identify adverse events as sentinel events when they meet criteria. The OIG also recommended facility leaders evaluate and improve processes to identify adverse events that warrant an institutional disclosure. In response, the Director reported

[60] A peer review is a "critical review of care performed by a peer" to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024. The OIG reviewed select peer reviews and the corresponding minutes from July 2023 and January, February, May, July, and September 2024.

[61] VHA Directive 1190(1).

[62] "Sentinel events are a subcategory of adverse events. A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of the duration of harm), or permanent harm (regardless of severity of harm)." The Joint Commission, *Comprehensive Accreditation Manual for Hospitals,* Sentinel Event Policy (SE), July 2024. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. An institutional disclosure is a "formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." VHA Directive 1004.08.

the Clinical Review Group, which includes patient safety managers, meets weekly to review adverse events and determine if they meet sentinel event and institutional disclosure criteria (see OIG Recommendations and VA Responses).

During an interview, staff discussed a patient event at a community-based outpatient clinic that involved a veteran who experienced a life-threatening emergency that required immediate action. The OIG visited the clinic and interviewed staff who said leaders reviewed the event for opportunities for improvement and developed action plans with target completion dates. The OIG also reviewed documents and found that staff had not implemented all improvement actions over 17 months after the event, despite their target completion dates. Lack of follow-up to ensure actions have been completed and sustained increases the potential for recurrence and future negative patient outcomes. The OIG recommended the Director implements processes to ensure staff track action plans until they are completed and report to leaders those that are outstanding. The Director stated that since November 2025, responsible staff have updated the Quality and Patient Safety Council on the status of overdue actions monthly (see OIG Recommendations and VA Responses).

During OIG interviews, staff described there was some confusion among staff as to their respective duties and roles, and the location of medical equipment. VHA Directive 1177 expects "emergency response capability to manage cardiac arrests on VHA property" that "includes access to appropriate resuscitation equipment and appropriately trained responders."[63] Moreover, facility policy requires designated staff to provide immediate medical assistance to patients, staff, or visitors experiencing medical emergencies.[64] The OIG recommended the Director ensures leaders train staff on their roles and responsibilities when responding to a medical emergency, including the location of equipment used for medical emergencies. The Director explained that nurses trained staff on emergency responses to medical events, and the OIG closed the recommendation (see OIG Recommendations and VA Responses).

Leaders reported they were revising their 2014 emergency response policy to help staff understand their roles and responsibilities during an emergency.[65] The OIG reviewed minutes from the Critical Care Committee and found the policy revision had been in progress for over two years. VHA Directive 0999(1) requires medical center policies be recertified five years from the date of publication.[66] The OIG recommended the Director ensures leaders revise the emergency response policy based on recertification time frames in VHA Directive 0999(1) or sooner, if warranted. In response, the Director reported leaders approved the facility's revised

[63] VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

[64] Central Alabama Veterans Health Care System Memorandum, No. 11-14-56, *Emergency Response to Medical Events*, August 6, 2014.

[65] Central Alabama Veterans Health Care System Memorandum, No. 11-14-56.

[66] VHA Directive 0999(1), *VHA Policy Management*, March 29, 2022, amended January 10, 2024.

standard operating procedure on October 29, 2025, and staff are receiving education about it (see OIG Recommendations and VA Responses).

Last, VHA Directive 1177 requires all clinical staff to maintain certification in basic life support.[67] The OIG found only 91 percent of clinical staff had current certifications as of November 20, 2024. The OIG recommended facility leaders ensure all applicable staff maintain basic life support certification and take appropriate action for those staff without it. The Director stated leaders assigned basic life safety training to clinical staff and have removed those without current certification or waivers from patient care (see OIG Recommendations and VA Responses).

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[68] 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.[69] 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.[70] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Facility leaders and the Management and Program Analyst for the Patient Centered Management Module identified staffing as the biggest challenge facing primary care teams.[71] The facility had

[67] VHA Directive 1177.

[68] VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

[69] 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).

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

[71] "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data, and allows national roll up of this data for tracking, case finding, and comparison purposes." VHA Directive 1406(2).

45 primary care teams, and according to the ADPCS, only 29 of them were fully staffed.[72] The ADPCS reported licensed practical nurse positions were the most difficult to fill due to the lack of training programs in the area. The ADPCS added that leaders had no problems recruiting registered nurses who graduated from the multiple nearby colleges.

Additionally, the Chief of Staff indicated recruiting physician providers to the more rural clinics could be challenging due to the lack of providers in central Alabama. The Associate Chief of Staff for Ambulatory Care described interest in adding a primary care physician residency program at the facility to help with recruitment. The associate chief also detailed their current process, which includes four float providers who do not belong to a specific team to help cover vacancies.

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.[73] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[74]

The OIG found 30 of the 45 primary care teams had panels over 100 percent of VHA's expected size. Additionally, comparing October 2023 to October 2024, the average panel size across the system increased from 90 to 107 percent. Panel sizes over capacity can negatively affect veterans' access to care and lead to staff burnout. The Associate Chief of Staff for Ambulatory Care stated that primary care leaders monitor appointment wait times and report to facility leaders weekly. In November 2024, the new patient appointment wait time was approximately 33 days, which exceeds VHA recommendations.[75]

The associate chief further explained they monitor and adjust panel sizes during monthly meetings and discuss potential new teams after panels reach maximum capacity; which would ideally occur at 85 to 90 percent. Similarly, the management and program analyst described meeting with primary care leaders during daily huddles and twice monthly formal meetings to discuss panel sizes and which teams had availability to receive new patients. For instance, the Chief of Staff provided an example of primary care staff encouraging patients to schedule appointments at clinics closer to their homes that may have more capacity.

The management and program analyst added the larger panel sizes were a problem for the primary care teams, and a provider agreed. Leaders acknowledged VHA staffing budget changes

[72] Primary care team staffing includes a provider, registered nurse, licensed practical nurse, and medical support assistant. VHA Directive 1406(2).

[73] "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).

[74] VHA Directive 1406(2).

[75] VHA expects primary care clinic wait times to be 20 calendar days or less. VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

had affected their ability to hire new staff and increase the number of teams. Despite the staffing challenges, the Chief of Staff and the Associate Chief of Staff for Ambulatory Care reported a goal of adding three new primary care teams over the next 12 months. The OIG recommended the Director ensures facility leaders manage primary care teams' panel sizes to support patients' access to care. In response, the Director described efforts to manage panel sizes including increased staffing, patient reassignments, and review of overcapacity teams (see OIG Recommendations and VA Responses).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[76] 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 staff said leaders share information during daily huddles and they feel supported by leaders. A physician reported feeling comfortable sharing ideas, suggestions, and challenges with the Chief of Staff. The physician and a licensed practical nurse discussed the importance of leaders following up on issues staff identify. Facility leaders acknowledged they did not always follow up but had improved over the past year.

Additionally, staff discussed challenges they faced during a typical day; the biggest obstacle was insufficient time to address patients' needs during 30-minute appointments. Staff also identified inefficiencies with the care in the community consult process, which was time-consuming and required frequent follow up with community providers to obtain patient notes and care plans.[77]

The Associate Chief Nurse for Ambulatory Care stated that leaders had analyzed primary care team workflow and efficiency in early 2024 and then held a multidisciplinary strategic planning summit for primary care to address identified issues and goals for improvement. The associate chief nurse shared one of the goals centered around supporting staff and provided an example of a mandatory program to train staff on the primary care model roles and responsibilities, and how to view an individual teams' quality metrics. The training is ongoing and will continue until all current and newly hired staff have completed it. The ADPCS and associate chief nurse added that leaders also developed a multidisciplinary workgroup to improve the efficiency of care in the community consults by improving communication between facility community care and primary care staff.

[76] VHA Handbook 1101.10(2).

[77] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "VA Community Care," Department of Veterans Affairs, accessed December 12, 2024, https://www.va.gov/communitycare.

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 reviewed enrollment data which showed a slight increase in veteran enrollment from FY 2022 through FY 2024 quarter two.

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.[78]

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).[79] 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."[80]

The HCHV Program Manager shared about a homeless veteran who contacted one of the facility's outpatient clinics requesting shelter, and staff there notified HCHV. Program staff assessed the veteran's needs, determined they would be best housed with a roommate, and found a space at a contracted housing site. While there, the veteran joined the facility's work therapy program, then gained full-time employment at the facility and later in the community.

Figure 8. *HCHV success story. Source: OIG analysis of questionnaire responses.*

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

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

[80] 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.

The OIG found the program did not meet the HCHV5 target from FYs 2021 through 2024 quarter three. The HCHV Program Manager identified barriers to meeting the goals such as staffing challenges that limit outreach efforts, especially in rural areas. For example, VHA staffing budget changes limited facility funding for two vacant social work positions dedicated to outreach. The HCHV Program Manager shared that outreach continues through collaboration with a community-based homeless program and local law enforcement. Staff also use the mobile medical unit to locate veterans in need.

The HCHV Program Manager shared that staff identify veterans in need of services through community outreach, referrals from the National Call Center for Homeless Veterans, the telephone triage clinic (a number veterans can call and be directed to appropriate services), and other facility staff.[81] The program manager further explained that once staff confirm a veteran's eligibility, they conduct a needs assessment and enroll the veteran in case management services.

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).[82] The OIG found the HCHV program did not meet the HCHV1 and HCHV2 targets from FY°2021 through 2024 quarter three.

The HCHV Program Manager identified limited income and past criminal history as some of the barriers to finding permanent housing for veterans. The manager shared they continue to work with contracted housing services so veterans can remain sheltered; however, when veterans do leave or are asked to leave, HCHV staff try to get them back to the shelter.

[81] "VA Homeless Programs, National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed September 3, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

[82] 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*.

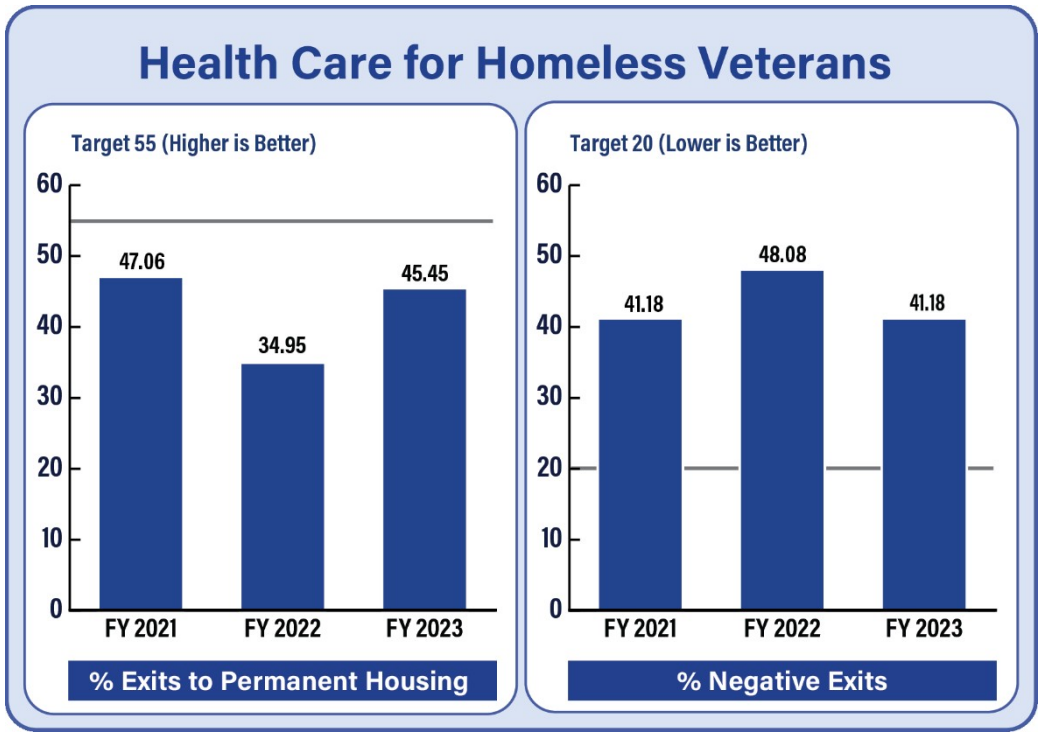

Figure 9. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program manager also explained the challenges of a geographically large service area including parts of Alabama and Georgia, some of it rural with limited transportation and housing. Where public transportation was unavailable, program staff relied on community partners and other facility staff to provide rides for veterans. The service area also included a college town with few affordable housing options, resulting in the transfer of housing vouchers to other communities.

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."[83] 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.[84]

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

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).[85]

The program met the target from FY 2021 through 2023 and performed just below the target in FY 2024 quarter three. In response to an OIG questionnaire, the Housing and Urban Development–Veterans Affairs Supportive Housing Lead attributed this success to staff teamwork and active engagement with veterans. Specifically, a social worker shared that the case management process involved addressing the causes of homelessness, for example, by teaching veterans how to monitor their budget, pay bills, and avoid overspending.

A Housing and Urban Development-Veterans Affairs Supportive Housing social worker shared a story of a veteran who entered the program in need of stable housing and employment. Through work with staff, the veteran received a housing voucher and gained full-time employment. The veteran remained in the program for six months, continuing to receive case management and supportive services until graduating and becoming able to pay rent without the aid of a voucher.

Figure 10. *Housing and Urban Development-Veterans Affairs Supportive Housing success story. Source: OIG analysis of questionnaire responses.*

Additionally, the program lead explained that outreach staff educate the community about the program's resources. For example, staff attend public housing authority fairs to educate landlords about renting to veterans and accepting housing vouchers. The lead also informed the OIG that when landlords express interest in accepting vouchers, staff use an internally developed form to collect and share detailed information about the property, including deposit amount and contact information.

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).[86] The OIG identified the program met the target for FYs 2021, 2022, and 2024 through quarter three but was slightly below the goal for FY 2023. A program social worker stated the employment specialist helped veterans build resumes and collaborated with community partners to supply interview attire and bus passes.

[85] 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*.

[86] 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*.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[87] 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.[88]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[89] The facility's program exceeded the target in FY 2023 but had not yet reached the goal in FY 2024 through quarter three. A program outreach staff member shared that conducting outreach, establishing trust, and helping veterans identify and meet their goals contributed to target achievement. Another staff member said staff conducted outreach using facility-provided vehicles to travel to jails, prisons, courts, and community partner locations. Through community staff connections, program staff met with inmates who reported a military history and may be eligible for services; and conducted assessments for potential treatment consults. The staff member said one jail proactively provided program staff with a list of inmates who reported military service.

Meeting Veteran Needs

A program staff member also reported care for enrolled veterans is coordinated with other facility programs and community partners. For example, staff consult an HCHV provider to complete the medical clearance assessments so veterans can be referred to available treatment programs. Another staff member stated that criminal justice partners provide veterans with information about legal requirements and eligible services.

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

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

[89] 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*.

Conclusion

The OIG is aware of the transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to the environment of care (crosswalk safety and cleanliness), patient safety (test result communication and adverse events), and primary care (panel sizes). Leaders have started to implement corrective actions, and completed corrective actions for one recommendation, which the OIG closed (see OIG Recommendations and VA Responses). 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

Facility leaders install detectable warning surfaces where crosswalks transition onto a vehicle roadway.

_X_ Concur

____ Nonconcur

Target date for completion: January 31, 2026

Director Comments

An assessment of detectable warning surfaces was conducted for the Tuskegee and Montgomery Campuses. It was found that 20 detectable warning surfaces were missing on the Tuskegee Campus, and one detectable warning surface was damaged on the Montgomery Campus.

Engineering has already ordered 20 detectable warning surfaces for the Tuskegee Campus and is pending receipt of a delivery date. The one damaged detectable warning surface on the Montgomery Campus has already been replaced. Compliance will be met when 100% of warning surfaces have been installed. This action will be monitored by the Chief of Engineering and tracked by and reported to the Environment of Care Committee (EOCC) through completion.

OIG Comments

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

Recommendation 2

Facility leaders ensure clinical staff who perform toxic exposure screenings complete mandatory training.

_X_ Concur

____ Nonconcur

Target date for completion: May 31, 2026

Director Comments

As of October 20, 2025, the compliance rate is 98.6% for the one-time Toxic Screening Reminder Training (TMS ID 131006048). The Chief of Staff Office and Education Services are collaborating to address remaining deficiencies. All new clinical providers are assigned training

during service line orientation to ensure compliance and expectations of screening prior to engaging in patient care.

The Ambulatory Care Associate Chief of Staff will report monthly to the Medical Executive Council all Toxic Exposure Screening (TES) Training delinquencies. Compliance will be tracked as a High-Risk Action Plan tracking both Primary and Secondary Toxic Exposure Screening completions. The Chief of Staff will also report compliance rates of Toxic Screening Training to the Executive Leadership Team during the monthly Governance Board meetings.

The numerator is the number of clinical personnel that have completed Toxic Screening Training Reminder (TMS ID 131006048). The denominator is the total number of VHA clinical personnel who may screen Veterans for toxic exposure concerns. The required personnel include any staff member who completes Stage 1 or Stage 2 of the Toxic Exposure Screening Clinical Reminder. The compliance goal is 98% or greater sustained for six consecutive (6) months.

OIG Comments

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

Recommendation 3

The Director ensures staff implement processes to prevent repeat environment of care findings related to dusty sprinkler heads.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

During Comprehensive Environment of Care (EOC) rounding, ten sprinkler heads will be randomly checked during each EOC round. To prevent repeat EOC findings related to dusty sprinkler heads, the sprinkler heads will also be inspected in conjunction with monthly fire extinguisher inspections and cleaned as identified. The numerator is the number of dusty sprinkler heads found during EOC rounds. The denominator is the total number of sprinkler heads assessed. Compliance will be met when no more than 10% show dust and must be sustained for six consecutive months. The results will be reported during the Environment of Care Committee monthly.

OIG Comments

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

Recommendation 4

Facility leaders evaluate all areas where biohazardous materials are located to ensure staff store clean and dirty items separately.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Monitoring will be achieved through EOC rounds in all areas where biohazardous materials are stored. In addition, a standard operating procedure for appropriate oxygen storage has been drafted and is in the final stages of leadership review.

For compliance measurement, the numerator is the number of rounds with no deficiencies related to the storage of oxygen tanks. The denominator is the number of EOC rounds including oxygen storage. Compliance is met when at least 90% of rounds include no deficiencies with oxygen storage for six consecutive months. Compliance will be reported to the Environment of Care Committee.

OIG Comments

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

Recommendation 5

The Director ensures staff keep the environment clean and safe.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

As of November 20, 2025, the Environmental Management Service (EMS) Chief and Assistant Chief positions are in the recruitment process. Vacancies for 13 environmental technicians, two supervisors, and two foremen are also being tracked. EMS Leadership are requesting a

modification of the existing contract to increase contracted EMS staff based upon identified needs.

The Interim EMS Chief is drafting standard operating procedures (SOP) based upon the latest national Environmental Program Services (EPS) SOPs and in accordance with VHA requirements. The new EMS SOPs will include core job aids to be implemented within six months. This timeframe includes training on the newly established SOPs.

Engineering continues to triage environment of care (EOC) and safety related work orders daily to determine priority. Engineering supervisors audit closed work orders to ensure the work orders have been appropriately addressed and closed. The Engineering Supervisor audits 10% of closed work orders weekly from the week prior. The numerator is the number of work orders addressed and closed appropriately. The denominator is the total number of closed work orders. Engineering will report audit results monthly to the EOC Committee until 90% compliance is met with sustainment for six consecutive months.

Identified deficiencies during EOC rounds are assigned to responsible services to be addressed within 14 business days. Action plans are submitted if additional time is needed based upon the complexity and/or severity of the deficiency.

The numerator is the number of closed EOC deficiencies, and the denominator is the total number of EOC deficiencies. Compliance is met when at least 90% of EOC deficiencies are closed and sustained for six consecutive months. Compliance will be reported to the Environment of Care Committee.

OIG Comments

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

Recommendation 6

Facility leaders ensure their policy aligns with VHA Directive 1088(1) and develop workflows for all services that communicate test results to patients.

_X_ Concur

____ Nonconcur

Target date for completion: January 30, 2026

Director Comments

A standard operating procedure (SOP), to include service level workflows, has been drafted and is in the final stages of review. Compliance will be met when the SOP and service level workflows are in accordance with VHA Directive 1088(1), completed, and education has been

provided to staff. The numerator is the number of service workflows completed, and the denominator is the number of services requiring workflows. Compliance will be reported to the Performance Improvement Committee and met at 100%.

OIG Comments

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

Recommendation 7

The Chief of Staff and Associate Director for Patient Care Services ensure corrective actions address unfavorable trends in communication of test result data.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

The communication of test results (CTR) workgroup will report action plans, audits, and progress towards compliance with VHA Directive 1088(1) to the Performance Improvement (PI) Committee monthly. The PI Committee reports to the Quality Patient Safety Council. The CTR workgroup created a facility-based action plan to address performance gaps by identifying existing workflows, barriers, and best practices within the facility.

As part of the External Peer Review Program process, when CTR 24 and 25 metrics are below 90%, the CTR workgroup is required to report corrective actions to the PI Committee monthly until at 90% or better compliance for six consecutive months.

OIG Comments

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

Recommendation 8

The Director ensures the Chief of Staff chairs and attends the Peer Review Committee meetings as required by VHA.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2026

Director Comments

The Peer Review Committee Meeting has been moved to the fourth Thursday of each month to ensure there are no scheduled calendar conflicts. The numerator is the number of meetings attended and chaired by the Chief of Staff. The denominator is the number of Peer Review meetings held. Attendance will be reported to the Medical Executive Council (MEC) and compliance met at 100% with sustainment for six consecutive months.

OIG Comments

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

Recommendation 9

The Director ensures patient safety managers identify adverse events as sentinel events when they meet criteria.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

The Quality Management Clinical Review Group consisting of the Risk Manager, Patient Safety Manager(s), Chief of Quality Management, Deputy Chief of Quality Management, and Performance Improvement Coordinators, meet at least weekly to review adverse events reported in Joint Patient Safety Reporting (JPSR).

Beginning in December 2025, the review process was modified to include all JPSR adverse events and the safety assessment code score for each event. As part of the modified process, the Clinical Review Group reviews the facts of the adverse event and the safety assessment code score. They also verify if the event meets the criteria of a sentinel event and if an institutional disclosure, Root Cause Analysis (RCA), and/or protected peer review(s) for quality management should be considered.

Quality Management conducts monthly audits of 10 random adverse events to ensure they are identified as a sentinel event when the criteria are met. Audits are reported to the Quality Patient Safety Council until 100% compliance is achieved for six consecutive months. The denominator is the number of events audited, and the numerator is the number of events accurately identified according to the sentinel event criteria.

OIG Comments

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

Recommendation 10

Facility leaders evaluate and improve processes to identify adverse events that warrant an institutional disclosure.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Beginning in December 2025, the Clinical Review Group review process was modified to include all adverse events. As part of the modified process, the Clinical Review Group reviews the facts of the adverse event and the safety assessment code score. They also verify if the event meets the criteria of a sentinel event and if an institutional disclosure should be recommended. The Risk Manager then meets with the Chief of Staff to review all adverse events recommended for institutional disclosure. The Associate Director of Patient Care Services is included in these reviews as necessary.

Quality Management conducts monthly audits of 10 random adverse events to ensure institutional disclosures are recommended when warranted according to VHA requirements. Audits are reported to the Quality Patient Safety Council until 100% compliance is achieved for six consecutive months. The denominator is the number of events audited, and the numerator is the number of events accurately identified according to VHA institutional disclosure requirements.

OIG Comments

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

Recommendation 11

The Director implements processes to ensure staff track action plans until they are completed and report to leaders those that are outstanding.

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2026

Director Comments

Historically, action plans related to the completion of root cause analysis (RCA) action items have been reported by Patient Safety and tracked monthly in the Quality and Patient Safety Council (QPSC). In November 2025, the responsible parties with overdue RCA actions began reporting status updates to actions and revised targets for closure monthly in QPSC until all overdue actions are complete. As of January 2026, the Executive Leadership Team member responsible will update QPSC on overdue RCA actions, assist in overcoming barriers, and ensure accountability until these actions are completed.

Compliance is met when 90% of RCA actions and outcome measures are closed by the target date for six consecutive months. The numerator is the number of RCA actions and outcome measures that are closed timely by the target date. The denominator is the total number of open RCA actions and outcome measures. Compliance will be reported to the Quality and Patient Safety Council monthly.

OIG Comments

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

Recommendation 12

The Director ensures leaders train staff on their roles and responsibilities when responding to a medical emergency, including the location of equipment used for medical emergencies.

_X_ Concur

____ Nonconcur

Target date for completion: Closed

Director Comments

Nurse educators provide emergency response to medical event training (Code Response training) to staff onboarded during monthly New Employee Orientation. The Code Response training curriculum teaches early identification of emergency situations, discusses individual role identification, provides facilitator-led simulated exercises, and evaluates appropriate response actions/interventions utilized, the location of medical equipment, and debriefing. In addition, this Code Response training was offered monthly to all staff (clinical and non-clinical). Mock codes are conducted as a component of the training. Thirty-six mock codes were conducted during FY25.

Nurse Educators reported on mock codes to the Critical Care Committee. Minutes have been provided as evidence of compliance with mock codes for (6) six months.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 13

The Director ensures leaders revise the emergency response policy based on recertification time frames in VHA Directive 0999(1) or sooner, if warranted.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Central Alabama Veterans Health Care System's (CAVHCS) Emergency Response Code Blue and Rapid Response standard operating procedure (SOP) has been revised and approved on October 29, 2025, with details specified for processes at both medical centers and for all community-based outpatient clinics.

Beginning November 2025, applicable staff at all hospital and clinical sites are being provided education on the revised Emergency Response Code Blue and Rapid Response SOP to include site specific processes and emergency response protocols. Live interactive classes are also offered at each location. Ongoing Emergency Response Code Blue and Rapid Response education will also be provided during New Employee Orientation for new staff.

The numerator is the number of staff that have received Emergency Response Code Blue and Rapid Response SOP education, and the denominator is the number of applicable staff. Compliance is met when at least 90% of applicable CAVHCS staff have received education. Compliance will be reported monthly in the Critical Care Committee.

OIG Comments

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

Recommendation 14

Facility leaders ensure all applicable staff maintain basic life support certification and take appropriate action for those staff without it.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2026

Director Comments

The basic life safety (BLS) coordinator has assigned BLS training to all clinical staff in the Resuscitation Education Innovation program for BLS training. Training is monitored and compliance is tracked in Talent Management System. Quarterly reports validate recertification. Clinical service leaders remove staff from direct patient care when BLS is not current or lacking approved waiver. Noncompliance will result in appropriate action by the supervisor. In January 2025, Education began sending compliance reports to managers on the 10th of each month to facilitate timely renewal.

To ensure compliance, 100% of all applicable staff in direct patient care will maintain current certification in quarterly BLS training. Staff not current in BLS will be removed from direct patient care until they are certified or an appropriate waiver approved. Compliance will be monitored until six consecutive months of compliance are met. Compliance will be reported to Medical Executive Council. The numerator is the number of applicable staff compliant with BLS certification that are in direct patient care. The denominator is the number of applicable staff in direct patient care.

OIG Comments

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

Recommendation 15

The Director ensures facility leaders manage primary care teams' panel sizes to support patients' access to care.

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2026

Director Comments

Staffing challenges have impacted key positions on Patient Aligned Care Teams (PACT) as identified in the 2025 OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Report.

Efforts to immediately manage panel sizes include hiring additional staff, utilizing the Clinical Resource Hub internal and external to the Veterans Integrated Service Network, reallocating patients to Women's Health teams with panel availability, reviewing the Patient-Centered Management Module capacity to validate the accuracy of panel size, and assessing Veterans with no visits in the past two years that are assigned to overpaneled teams.

- For compliance, the goal will be to reduce by 10% the number of PACT teams paneled over 110%. To demonstrate sustainment, this improvement will be maintained for six consecutive months.

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.[90] 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. 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.*[91]

Potential limitations include self-selection bias and response bias of respondents.[92] 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 November 19 through 21, 2024. 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[93] The OIG reviews available evidence within a specified

[90] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

[92] 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.

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

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.

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.*

† *A September 5, 2025, executive order designated the Department of War as a secondary title for the Department of Defense. Restoring the United States Department of War, 90 Fed. Reg. 43893 (Sep. 10, 2025).*

Appendix C: Additional Facility Photos

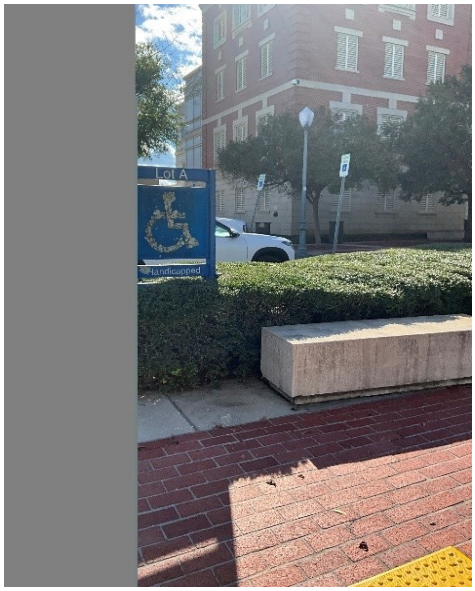

Figure C.1. *Example of a faded sign.*
Source: Photo taken by OIG inspector.

Figure C.2. *Example of a faded sign without illumination.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 14, 2025

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery

To: Director, Office of Healthcare Inspections (54HF03)

Director, Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery. I have completed a full review of the draft report and concur with the findings. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values.
2. I concur with the recommendations and action plan submitted by the Central Alabama VA Health Care System in Montgomery. In addition, I concur with the request for closure of recommendations 12 and 13.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA, FACHE
Network Director

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 21, 2025

From: Director, VA Central Alabama Health Care System (619)

Subj: Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery

To: Director, VA Southeast Network (10N7)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Facility Inspection of the VA Central Alabama Health Care System in Montgomery as part of a continuing process to improve the care of our Veterans. Central Alabama Veterans Health Care System Center remains committed to ensuring our Veterans receive healthcare of the highest quality.
2. Central Alabama Veterans Health Care System submits the attached status request update requesting closure of Recommendations 12 and 13.
3. If you have any questions or require further information, please contact the Chief, Quality Management.

(Original signed by:)

Amir Farooqi, FACHE
Executive Director
Central Alabama Veterans Health Care System

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