US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Battle Creek Healthcare System in Michigan

Healthcare Facility Inspection	25-00238-44	February 3, 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 all recommendations.

What the OIG Found

The OIG physically inspected the VA Battle Creek Healthcare System (facility) from May 20 through 22, 2025.[1] 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), and both employees' and veterans' experiences. Executive leaders identified recent presidential actions (executive orders and memorandums) that required short response times, and staff's return to the office as system shocks.[2] Additionally, the aging infrastructure causes challenges for repairs and improvements.

Executive leaders also described how they manage the implementation of the new electronic health record system.[3] The facility and three other VA medical centers in Michigan will deploy the new system at the same time in April 2026.[4] Executive leaders further explained the four facilities use a collaborative market approach to provide health care in the area to improve care for veterans and be good stewards of money and resources.

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[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] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[3] In 2018, VA awarded a contract to Oracle Health Millenium (Oracle) for a new electronic health record system. "What is the FEHRM [Federal Electronic Health Record Modernization]?," Federal Electronic Health Record Modernization, accessed July 8, 2025, https://www.fehrm.gov/about-fehrm/.

[4] The other three Michigan sites are the VA Detroit Healthcare System, VA Ann Arbor Healthcare System, and VA Saginaw Healthcare System. "Deployment Schedule," Federal EHR [Electronic Health Record] Resource Center, accessed October 15, 2025, https://dvagov.sharepoint.com/sites/DeploymentSchedule. (This website is not publicly accessible.)

The Director said leaders feel prepared for the new system because they had previously worked through the implementation phases before VA stopped to reset the process in 2023, and they stay informed about sites that already use the new system.[5] For example, they learned they will need to hire more pharmacists based on another facility's challenges with the system.

Environment of Care

The OIG examined transit and parking, the main entrance, and navigation support (features that help people find their way around). The OIG also inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The facility had multiple buildings and parking lots next to building entrances. The OIG found the main entrances clean, with information desks and generally up-to-date navigational signs. The OIG also noted the facility had some resources available for patients with sensory impairments, but common area televisions did not consistently use closed captioning.

The OIG identified additional areas that lacked a safe, clean, and functional environment. For example, the OIG observed dust on bed frames and supply shelves. Further, the OIG found facility staff did not document inspections for some defibrillators.[6] Staff used one of the devices for a veteran who had a medical emergency, but upon review of the electronic health record, the device was used to monitor the patient's heart rhythm, not to defibrillate. Additionally, the OIG found some equipment lacked preventive maintenance stickers or had stickers that indicated maintenance was past due, but staff had documented they completed the maintenance. The OIG made recommendations to improve safety and cleanliness.

In response, the Director stated leaders implemented actions to strengthen accountability and monitoring. Leadership rounding activities included Environmental Management Service leaders performing audits of terminal cleaning to uphold standardized expectations of cleanliness. The Director also stated leaders implemented a comprehensive plan to ensure Healthcare Technology Management Service staff consistently inspected, tested, and documented all medical equipment maintenance according to required schedules. In addition, several actions were completed and embedded into routine operations including the addition of a log line in the work orders for staff to confirm sticker placement. Therefore, the OIG closed the recommendations.

[5] Department of Veterans Affairs, "VA Announces Reset of Electronic Health Record Project," news release, April 21, 2023, https://news.va.gov/press-room/reset-of-electronic-health-record-project/; VA OIG, *Facility Leaders and Staff Have Concerns About VA's New Electronic Health Record*, Management Advisory Memo No. 24-02874-256, September 23, 2024. Appendix A of this advisory memo includes information on OIG reports published on this topic since 2020.

[6] "Defibrillators are devices that apply an electric charge or current to the heart to restore a normal heartbeat." "What are Defibrillators?," National Heart, Lung, and Blood Institute, accessed June 3, 2025, https://www.nhlbi.nih.gov/defibrillators.

The OIG reviewed a previous accreditation survey report by The Joint Commission, which included findings of expired food and reagent solutions (used to ensure blood sugar testing devices provide accurate results).[7] The OIG observed similar findings during the physical inspection and made a recommendation to prevent repeat environment of care issues. In response, the Director stated staff used a standardized checklist to ensure all required cleaning steps were completed and reinforced consistent expectations, and therefore, the OIG closed the recommendation.

Patient Safety

The OIG assessed the facility's processes to communicate urgent, noncritical test results to providers and patients; sustain changes made in response to previous oversight recommendations; and implement continuous learning methods to identify opportunities for improvement. The OIG found staff developed a facility policy for the communication of test results and implemented service-level workflows, but they did not clearly define the roles of team members, as required in VHA Directive 1088(1).[8]

A leader explained the process for staff to communicate patient test results but acknowledged there was not a written process specifying types of test results each team member can communicate. Facility leaders also said staff monitored test result communication through monthly audits and the external peer review program.[9] The OIG reviewed the audit data from fiscal years 2024 and 2025 and noted overall improvement but made a recommendation to improve service-level workflows. In response, the Director stated staff created clearer, more precise guidance to ensure service-level workflows explicitly define each staff member's role in communicating test results, and therefore, the OIG closed the recommendation.

The OIG noted facility staff had maintained compliance for a closed recommendation related to suicide risk evaluations from the prior Comprehensive Healthcare Inspection Program report.[10] The OIG also found staff were aware of and engaged in process improvement activities. Staff shared a recent project that helped reduce medication errors.

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[7] The Joint Commission performed hospital, behavioral health and human services, and home care accreditation inspections in July 2024. The Joint Commission, *Final Accreditation Report: Battle Creek VA Medical Center*, August 2, 2024.

[8] A service-level workflow is "a written document that describes the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[9] The external peer review program provides an independent review of medical records to assess the quality of care provided at the VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, March 7, 2022, accessed September 15, 2025. https://vaww.qps.med.va.gov/divisions/api/pm/cpm. (This website is not publicly accessible.)

[10] VA OIG, *Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan*, Report No. 22-04038-82, February 20, 2024.

Primary Care

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2) and received support from leaders.[11] At the time of the site visit in May 2025, there were eight provider and two advanced medical support positions vacant. The OIG found 44 primary care teams were fully staffed, although some teams were being covered by float (facility staff who cover vacant positions) or contracted providers.

The facility's panel sizes (number of patients assigned to a primary care team) averaged 96 percent of the size for calendar year 2024 as recommended by VHA Directive 1406(2).[12] Average appointment wait times for new and existing patients were under 10 days, which is better than the recommendation of 20 calendar days or less, as stated in VHA Directive 1231(4).[13]

Veteran-Centered Safety Net

The OIG reviewed the facility's homeless programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. Staff reported they work collaboratively across the programs to address veterans' needs and by cross-training staff to work as one team. Staff receive referrals from a variety of sources including facility and community providers, community partners, homeless clinics, landlords, courts, and jails.

The homeless programs met or exceeded VHA targets in most reviewed metrics. Staff proudly shared how they helped the first Michigan county to declare an end to veteran homelessness, which is a significant milestone.[14]

For performance metrics that did not meet targets, staff identified barriers including lack of affordable and safe housing, public housing agency funding challenges, and landlords who had not maintained their properties, which required veterans to relocate. Although the Veterans Justice Program exceeded targets, staff reported barriers such as incarceration release dates that changed and specific criminal charges that make it more challenging to find housing.

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[11] VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[12] The baseline capacity for a full-time primary care team with a physician provider is 1,200 patients, depending on patient characteristics and level of clinic staff and administrative support. VHA Directive 1406(2).

[13] 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.

[14] "Ending Veteran Homelessness," Department of Veterans Affairs, accessed July 31, 2025, https://www.va.gov/EndingVetshomelessness.asp.

What the OIG Recommended

1. The Director ensures staff keep the environment clean and safe.
2. The Director ensures Healthcare Technology Management Service staff inspect, test, and properly document all medical equipment maintenance per their required schedule.
3. The Director ensures staff implement processes to prevent repeat environment of care findings identified in this report.
4. Facility leaders ensure service-level workflows include each staff member's role in the communication of test results process.

VA Comments and OIG Response

The interim Veterans Integrated Service Network Director and acting facility Director concurred with recommendations 1 through 3, concurred in principle with recommendation 4, and provided acceptable improvement plans (see responses in the body of the report and appendixes D and E for the full text of the directors' comments). Based on information provided, the OIG considers all recommendations closed.

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

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

FACILITY IN CONTEXT

VA Battle Creek Healthcare System
Battle Creek, Michigan
Level 2-Medium Complexity
Calhoun County
Hospital Referral Region: Kalamazoo

Description of Community

POPULATION

Female **643,691**	Male **633,946**
Veteran Female **6,978**	Veteran Male **70,058**

Homeless - State **8,206**
Homeless Veteran - State **498**

MEDIAN INCOME

$56,897

EDUCATION

91% Completed High School
59% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **289**

SUBSTANCE USE

29.1% Driving Deaths Involving Alcohol
20.9% Excessive Drinking
284 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	474,506
Carpool	51,965
Work at Home	31,061
Walk to Work	14,342
Other Means	6,468
Public Transportation	4,419

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**27.5 Minutes, 21 Miles**
Specialty Care	**50.5 Minutes, 44 Miles**
Tertiary Care	**100.5 Minutes, 104 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **13,154**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	32%
<65 without Health Insurance	11%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

13,087

115 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

N/A

30-DAY READMISSION RATE

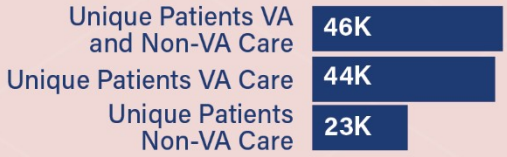
N/A

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
18	31

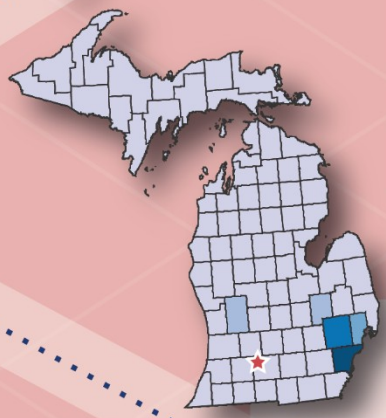
Health of the Facility

UNIQUE PATIENTS



COMMUNITY CARE COSTS

Unique Patient	Outpatient Visit
$26,829	$345
Line Item	**Bed Day of Care**
$863	$375



STAFF RETENTION

Onboard Employees Stay <1 Yr	14.81%
Facility Total Loss Rate	12.74%
Facility Retire Rate	2.57%
Facility Quit Rate	8.69%
Facility Termination Rate	1.37%

★ VA MEDICAL CENTER

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 1,380 healthcare facilities.[1] VHA's vast care delivery structure requires 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 review includes a set of content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net.

Healthcare Facility Inspection reports provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care delivered; and highlight specific actions leaders and staff can take to improve patient safety and care.

In 2018, VHA officially began the journey to become a high reliability organization (HRO) and set goals to improve accountability and reliability and reduce patient harm.

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

The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[2] VHA has now implemented HRO principles at all VHA facilities.[3]

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[1] "About VHA," Department of Veterans Affairs, accessed August 8, 2025, https://www.va.gov/health/aboutvha.

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

[3] "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.)

Content Domains

Figure 2. *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 VA Battle Creek Healthcare System (facility), which opened as the Battle Creek Veterans Hospital (Veterans Hospital Number 100) in 1924, recently celebrated 100 years of providing care to veterans. Over half the buildings at the facility's Battle Creek VA Medical Center are on the National Register of Historic Places. Executive leaders said the facility's budget for fiscal year (FY) 2024 was approximately $639 million. It had 216 total operating beds (75 community living center, 101 domiciliary, and 40 inpatient mental health beds).[4]

Figure 3. *Battle Creek VA Medical Center. Source: "VA Battle Creek Health Care," Department of Veterans Affairs, accessed March 26, 2025, https://www.va.gov/battle-creek-health-care.*

The OIG inspected the facility from May 20 through 22, 2025. The executive leadership team consisted of the Director, Chief of Staff, Associate Director for Patient Care Services, and Associate Director.

CULTURE

The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's usual daily operations), and both employees' and veterans' experiences.[5] The OIG administered a facility-wide questionnaire, reviewed VA's All Employee Survey scores, interviewed leaders and employees, and reviewed data from patient advocates and veterans' feedback.[6]

[4] "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.asp. 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.

[5] 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.

[6] The All Employee Survey is an annual, voluntary 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. Patient Advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed August 4, 2025, https://www.va.gov/HEALTH/patientadvocate/. 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.

System Shocks

The Director identified recent presidential actions (executive orders and memorandums) as a system shock. The Director explained the actions resulted in a vast amount of information requests from VA, and leaders had to act quickly. Additionally, in response to the requirement for federal employees to return to in-person work, leaders discussed their extensive planning to arrange office accommodations for over 500 employees.[7]

The OIG received 342 responses to the facility-wide questionnaire, many of which contained statements about the presidential actions and how they have negatively affected work life, including employees' concerns about whether they will continue to have a job. In response to changes directed by the actions, the Director said leaders adjusted their communication tools, similar to how they provided information during the COVID-19 pandemic. For example, they host fireside chats (informal but structured meetings) to answer questions, get employees' input, and discuss concerns; the Director also sends a weekly wrap-up email to all employees.

Executive leaders also described aging infrastructure as a significant challenge. For example, a current project to improve water quality for sterile processing requires upgrades to water systems and pipes in older buildings to meet quality standards. However, limited access to the pipes, tree root intrusion, and other structural issues have delayed the upgrades. In the meantime, employees plan to send equipment to the facility's Wyoming VA Clinic for sterilization as needed.

Oracle Electronic Health Record Implementation

VA's updated Oracle Electronic Health Record Implementation schedule has the Battle Creek facility and three other Michigan sites as the first to deploy.[8] The Director reported the deployment date is April 11, 2026. The Director described believing the simultaneous deployment was to build on the strength of the partnership, called the Michigan Market, which includes all VA Michigan facilities. The Director reported that the Michigan Market formed specialty hubs, such as cardiology, where veterans can access specialty providers from other VA facilities. In some cases, veterans who were eligible for community care chose to receive care in the VA system because of what this market offers.[9] Additionally, when another facility in the market had a medical coding backlog, the Associate Director said staff from VA Battle Creek Healthcare System quickly helped eliminate it.

[7] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

[8] The other three sites are the VA Detroit Healthcare System, VA Ann Arbor Healthcare System, and VA Saginaw Healthcare System. "Deployment Schedule," Federal EHR [Electronic Health Record] Resource Center, accessed October 15, 2025, https://dvagov.sharepoint.com/sites/Deployment. (This website is not publicly accessible.)

[9] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed November 1, 2024, https://www.va.gov/community.

The Director further explained that leaders are prepared for Oracle because they previously worked through its implementation phases and have learned from facilities that already use the system. For example, because staff at the VA Central Ohio Health Care System in Columbus experienced pharmacy challenges, the Director noted leaders will need to hire more pharmacists.[10] During the initial implementation phases, which started approximately three weeks prior to the site visit in May 2025, executive leaders said they worked with staff to reduce the amount of manual entries needed for the new system, in part by ensuring data in the current system are accurate so they transfer correctly to Oracle.

During interviews, staff confirmed they were aware of Oracle's deployment date, and said leaders communicated implementation updates through meetings, town halls, and from staff specifically assigned to the project. The director stated that upcoming workshops will help teams evaluate their current work processes and decide whether changes are needed to align with the new system.

Employee Experiences

The OIG also reviewed VA survey results related to best places to work and no fear of reprisal and found scores did not change from FYs 2023 to 2024. During interviews, the Director explained that because it is a rural facility and one of the area's largest employers, employees who are unhappy might not leave due to a lack of other opportunities.

The Director explained that organizational changes were another area of dissatisfaction for some employees. For instance, leaders closed the inpatient medical-surgical unit due to consistently low patient volume, which averaged only two to three patients per day. They also restructured the 24-hour emergency department into a 12-hour urgent care clinic, open seven days a week. In addition, the prior organizational structure had several services under one leader, and they reorganized services to better align with the work employees perform, which allowed for better oversight and communication. While leaders made these changes to support operational efficiency, employees assigned to these areas experienced disruptions.

The Associate Director also described efforts to improve executive leadership skills, including working with a consultant to complete a leadership impact assessment to identify needed changes. Executive leaders said they hold daily briefings (tiered huddles), round with all four executive leaders together (visit employees in their workspaces), and conduct town halls and

[10] VA OIG, *Electronic Health Record Modernization Caused Pharmacy Related Patient Safety Issues Nationally and at the VA Central Ohio Healthcare System in Columbus*, Report No. 23-01450-114, March 21, 2024.

safety forums, which provide opportunities to identify both successes and areas for improvement.[11]

The OIG found that survey results related to workgroup psychological safety declined from FYs 2023 to 2024.[12] During interviews, executive leaders reported they empower frontline employees to speak up about concerns in their areas, and the Associate Director said they receive information from services daily on issues involving staffing or safety.

When employees identify safety concerns, leaders recognize them, such as through good catch awards.[13] The Associate Director for Patient Care Services explained that pharmacy employees were recognized with a good catch award due to consistently reporting safety concerns. The Director described another safety concern: community living center employees identified they were running out of wound dressing material and reported it to leaders through the daily briefing process. Executive leaders monitored the issue until supply levels were appropriate to support patient needs.

Veteran Experiences

Patient advocate responses to an OIG questionnaire highlighted a common complaint about veterans wanting to change their healthcare providers. During interviews, the Chief of Staff explained that when a provider leaves, staff assign the veterans to another team, but veterans may want to choose their new provider instead. The chief added they support veterans' preferences when they can.

To improve veterans' experiences, executive leaders stated they conduct town halls and outpatient clinic meetings to inform them about any facility changes and share information, which includes topics such as community care and women's health. The Director said the facility also offers a broad range of mental health services in which staff host a variety of activities that give leaders many opportunities to interact with veterans. During the OIG's inspection in May 2025, for example, leaders provided opening remarks for an on-site event and visited with female veterans in the residential program.

[11] Tiered huddles are daily communications to multiple levels of staff (i.e., frontline staff, service-level leaders, and executive leaders) as part of the HRO journey. VHA, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*.

[12] "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.

[13] A good catch award recognizes staff who identify and report an error or prevent a potentially harmful event. "Employee Awarded for Commitment to Patient Safety," Department of Veterans Affairs, accessed September 3, 2025, https://www.va.gov/tennessee-valley-health-care/stories.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[14] The OIG assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The OIG also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[15]

General Inspection

The OIG used a commercial navigation application to travel to the Battle Creek VA Medical Center and Wyoming VA Clinic (one of the facility's outpatient clinics) and found directions to both sites easy to follow. On arrival at each location, the OIG observed directional signs to buildings, and parking lots near the entrances.

The medical center has multiple buildings with individual entrances, and most buildings are connected by an enclosed walkway. The OIG assessed the medical center's main entrance in building 2, which provides access to outpatient services, as well as the Wyoming VA Clinic's entrance. The OIG observed a passenger loading zone, power-assisted doors, and available wheelchairs at both entrances. A nonprofit organization operates the medical center's nine-hole golf

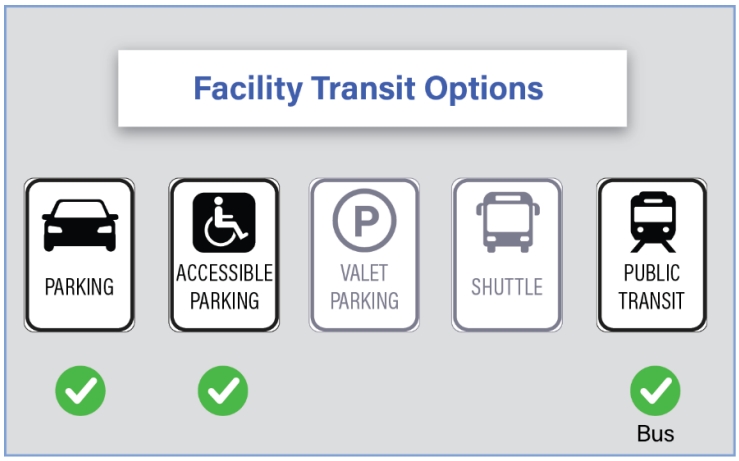

Figure 4. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and questionnaires.

[14] "Informing Healing Spaces through Environmental Design: Thirteen Tips," Department of Veterans Affairs, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[15] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; 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.

Figure 5. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of questionnaires and observations.

course that supports veterans' rehabilitation and recovery. Additionally, the OIG found the entrance lobbies generally clean and well-lit, with seating areas. There were information desks with staff or volunteers to assist veterans with directions.

In addition to information desk staff or volunteers who help with navigation, the OIG found maps and directional signs throughout the buildings at both locations. However, at the medical center, internal navigational signs were not consistently located at decision points (where a person must choose whether to continue along the current route or change direction) leading to the Urgent Care Center, which could make it difficult to find. The Interior Designer reported ordering updated signs, so the OIG did not make a recommendation.

The OIG observed multiple assistive features such as signs with large print and braille. Information desk staff and volunteers reported they help those with visual impairments get to their location, communicate with hearing-impaired individuals in writing, and request translation services when needed. The OIG also observed televisions in multiple common areas but noted closed captioning was not consistently available.

The OIG observed dust on bed frames (beneath mattresses) and on supply shelves. According to The Joint Commission *Standards Manual*, staff must maintain a "safe, functional environment."[16] The Chief of Environmental Management Service described trying to fill many vacancies and stated current staff received training but were inattentive, and supervisors did not routinely inspect rooms after cleaning.

Recommendation 1

The Director ensures staff keep the environment clean and safe.

__X__ Concur

____ Nonconcur

[16] The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, March 30, 2025.

Target date for completion: Completed

Director Comments

The Associate Director reviewed the recommendation and confirmed that no additional factors contributed to noncompliance. Recognizing that maintaining a clean and safe environment in health care facilities is complex and requires multiple layers of oversight—since issues such as dust can arise despite strong preventive measures—several actions were implemented to strengthen accountability and monitoring. Leadership rounding activities included Environmental Management Service (EMS) leaders performing audits of terminal cleaning to uphold standardized expectations of cleanliness and reinforce a culture of safety. Additionally, the Comprehensive Environment of Care Committee (CEOC), chaired by the Associate Director and composed of representatives from Facilities Management Service (FMS), EMS, Patient Safety, and Infection Control, conducted structured weekly rounds to proactively identify and correct deficiencies. To ensure long-term sustainment, the EMS Supervisor conducted monthly audits of terminally cleaned rooms using a standardized checklist to verify completeness and quality of cleaning performed by Housekeeping Aids. Audit data were collected and reported monthly to the Quality Patient Safety Board (QPSB), and compliance was consistently maintained at or above 90%. Progress was reviewed during QPSB meetings, and corrective actions were documented and tracked until fully resolved, embedding these improvements into routine practice.

OIG Comments

The OIG considers this recommendation closed.

The OIG also found problems with medical equipment maintenance. The OIG observed stickers affixed to medical equipment to show when staff last performed scheduled maintenance and when it was due again (see appendix C, figure C.1); however, the OIG found a defibrillator in a patient care area that lacked an inspection sticker and another that was overdue for maintenance.[17] According to The Joint Commission *Standards Manual*, staff must inspect, test, and maintain all medical equipment and document these activities.[18] Further, VHA Directive 1860 requires the facility's chief biomedical engineer to ensure staff keep medical

[17] "Defibrillators are devices that apply an electric charge or current to the heart to restore a normal heartbeat." "What are Defibrillators?," National Heart, Lung, and Blood Institute, accessed June 3, 2025, https://www.nhlbi.nih.gov/health/defibrillators.

[18] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, March 30, 2025.

equipment in working condition.[19] If staff do not regularly maintain medical equipment, it may malfunction during use.

Through a review of the facility policy and interviews, the OIG learned the facility's procedure was for biomedical staff to document they completed preventive maintenance in an electronic tracking system and place stickers on the devices to inform others they are safe to use. The Chief of Healthcare Technology Management Service explained that a supply chain management staff member documented the defibrillator that lacked an inspection sticker was decommissioned (removed from inventory). Therefore, staff would not have inspected it. The chief could not explain why the uninspected defibrillator remained in a patient care area. Likewise, the Chief of Supply Chain Management Service explained that staff mistakenly decommissioned the defibrillator and should have documented that it was transferred to the Healthcare Technology Management Service instead. For the other defibrillator with overdue maintenance, facility staff provided documentation they had inspected it but neglected to update the sticker.

Furthermore, the OIG reviewed facility documents and determined staff did not inspect two other defibrillators; based on this finding, the OIG requested additional information regarding use of the devices. Staff used one of them on a patient who experienced a medical emergency. The OIG also reviewed the electronic health record, which showed staff used the device to monitor the patient's heart rhythm, not to defibrillate the patient. Once the OIG identified the missing inspections, staff inspected the defibrillators and reported the devices passed inspection.

Additionally, the OIG found other medical equipment that lacked stickers or had stickers indicating scheduled maintenance was past due, but staff had documented they completed maintenance in the electronic tracking system. The Supervisory Biomedical Equipment Support Specialist explained the technician placed incorrect stickers on some equipment. The Chief of Healthcare Technology Management Service added that staff may inadvertently remove equipment stickers during cleaning, and they have tried different stickers to find ones that adhere better.

Recommendation 2

The Director ensures Healthcare Technology Management Service staff inspect, test, and properly document all medical equipment maintenance per their required schedule.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

[19] VHA Directive 1860, *Healthcare Technology Management Continuous Performance Monitoring and Improvement,* August 19, 2024.

Director Comments

The Associate Director reviewed the recommendation and confirmed that no additional factors contributed to noncompliance. A comprehensive plan was implemented to ensure Healthcare Technology Management Service (HTMS) staff consistently inspected, tested, and documented all medical equipment maintenance according to required schedules. To strengthen documentation practices, several actions were completed and embedded into routine operations. Biomedical Equipment Support Specialists (BESS) added a log line in Maximo work orders to confirm sticker placement. Beginning in September 2025, HTMS supervisors conducted monthly spot checks on 20 randomly selected medical equipment inspections to verify documentation accuracy and sticker placement, with results reported to the Quality Patient Safety Board (QPSB). Additionally, weekly Environment of Care (EOC) rounding results—including any discrepancies related to stickers—were tracked and reported to QPSB monthly. Compliance was monitored regularly, and documentation of preventive maintenance activities in Maximo, along with proper sticker placement, was consistently maintained at or above 90%. Any identified noncompliance triggered immediate corrective action, ensuring sustained adherence and reinforcing a culture of accountability.

OIG Comments

The OIG considers this recommendation closed.

The OIG reviewed the most recent Joint Commission accreditation report, which included findings of expired food and reagent solutions (used to ensure blood sugar testing devices provide accurate results), that facility staff reported to The Joint Commission as resolved.[20] However, the OIG observed similar deficiencies involving expired food and reagent solutions, which indicated staff had not sustained improvements. VHA Directive 1608(1) requires facilities to adhere to regulatory and accrediting bodies' requirements and ensure the healthcare environment is safe and clean.[21]

The Associate Director explained quality management staff previously tracked action plans for accreditation findings to ensure service staff completed them; however, now staff from the responsible service monitor the action plans. The Associate Director said budget-mandated staffing reductions at the facility have made it difficult to oversee many processes, and leaders are actively recruiting to fill vacancies.

[20] The Joint Commission performed hospital, behavioral health and human services, and home care accreditation inspections in July 2024. The Joint Commission, *Final Accreditation Report: Battle Creek VA Medical Center*, August 2, 2024.

[21] VHA Directive 1608(1).

Recommendation 3

The Director ensures staff implement processes to prevent repeat environment of care findings identified in this report.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Associate Director reviewed the recommendation and confirmed that no additional factors contributed to noncompliance. To prevent recurrence of Environment of Care findings, steps were implemented to strengthen processes and accountability. These actions included the daily use of a standardized checklist to ensure all required cleaning steps were completed, reinforcing consistent expectations and promoting a culture of safety. Additionally, the Comprehensive Environment of Care Committee (CEOC), chaired by the Associate Director and comprised of representatives from Facilities Management Service (FMS), Environmental Management Service (EMS), Patient Safety, and Infection Control, conducted structured weekly rounds to proactively identify and correct deficiencies. Compliance was monitored monthly by the Quality Patient Safety Board (QPSB), and adherence to checklist standards was consistently maintained at or above 90%. Progress was reviewed during QPSB meetings, and corrective actions were documented and tracked until fully resolved, ensuring that improvements were sustained and embedded into routine operations.

OIG Comments

The OIG considers this recommendation closed.

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

Communication of Urgent, Noncritical Test Results

The OIG reviewed the facility's policy, which included service-level workflows but lacked detail about which test results specific staff can communicate and how they should communicate

them.[22] VHA Directive 1088(1) requires staff to develop a policy for communicating test results and service-level workflows that identify staff members' roles in the process, the types of test results each team member can communicate, and how they must communicate them.[23] The Associate Chief of Staff for the Medicine Service reported providers inform nurses which results they can communicate to patients; licensed practical nurses can only communicate normal results or those that do not require intervention. The Chief of Staff said providers must communicate any critical test results or new diagnoses, such as cancer.

Recommendation 4

Facility leaders ensure service-level workflows include each staff member's role in the communication of test results process.

__X__ Concur in Principle

____ Nonconcur

Target date for completion: Completed

Director Comments

The Director reviewed the recommendation and concurred in principle. Battle Creek VA acknowledges that while service-level workflows included staff roles in the communication process, the structure was not as clear as intended and occasionally led to confusion. Importantly, this did not impact compliance with test result notification requirements. This recommendation provided an opportunity to strengthen policy by creating clearer, more precise guidance to ensure service-level workflows explicitly define each staff member's role in communicating test results. In response, Battle Creek VA reviewed and updated its policy to include a role-specific table that identifies who may communicate test results to patients, along with approved methods and documentation requirements. Service workflows were revised to reflect these clarifications. Additionally, in preparation for the transition to the Federal Electronic Health Record Modernization (EHRM) system in April 2026, a draft updated policy incorporates EHRM-specific processes and further defines staff roles in test result communication.

OIG Comments

The OIG considers this recommendation closed.

[22] VHA Directive 1088(1).

[23] VHA Directive 1088(1).

When asked how staff monitor test result communications, the Chief of Staff explained that staff review information obtained from the external peer review program and conduct monthly audits in the electronic health record system and report the information to the Clinical Executive Board.[24] The OIG reviewed monthly audit data from July through September 2024 and found some services were consistently below the facility's established benchmark of 90 percent compliance with communicating test results.

The Chief of Quality and Patient Safety stated staff inconsistently documented they communicated test results in the electronic health record, which made auditing difficult, and was a barrier to compliance. To improve the process, the Chief of Staff said informatics staff created an electronic template to document these communications. For the services with audit data below the benchmark, the Chief of Staff described meeting with the service chiefs to have them identify barriers and review the facility policy; the chief also educated providers on documentation requirements. Staff provided the OIG with audit data for October through May 2025 that reflected continued improvement; in May 2025, all but one service was over 90 percent compliant with requirements.

Action Plans and Process Improvements

The OIG reviewed reports, surveys, and reviews involving the facility for the past three years and did not find any open recommendations.[25] The OIG reviewed a closed recommendation related to suicide risk evaluations from the prior comprehensive healthcare inspection report and found staff had sustained compliance.

The Associate Director for Patient Care Services described receiving alerts to patient safety issues in several ways, including a monthly meeting with quality staff and daily meeting where leaders discuss adverse events and process improvements. Additionally, the Chief of Quality and Patient Safety stated the Quality Patient Safety Board discusses patient safety issues and activities. The activities included safety forum presentations on entering data into the Joint Patient Safety Reporting system and lessons learned from patient incidents, an annual quality fair, and patient safety visits to care areas with a school bus–themed cart used to prompt discussion and distribute educational materials.[26]

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[24] The external peer review program provides an independent review of medical records to assess the quality of care provided at the VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, March 7, 2022, accessed September 15, 2025, https://vaww.qps.med.va.gov/divisions/api/pm/cpm. (This website is not publicly accessible.)

[25] VA OIG, *Comprehensive Healthcare Inspection of the Battle Creek VA Medical Center in Michigan*, Report No. 22-04038-82, February 20, 2024; VA OIG *Insufficient Mental Health Treatment and Access to Care for a Patient and Review of Administrative Actions in Veterans Integrated Service Network 10*, Report No. 23-01601-208, July 31, 2024; The Joint Commission, *Final Accreditation Report Battle Creek VA Medical Center*.

[26] The Joint Patient Safety Reporting system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

Systems redesign staff said they identify opportunities for improvements from staff's and executive leaders' suggestions, root cause analysis actions, and process improvement training.[27] They facilitated a project to streamline the medication reconciliation process (a process to ensure accurate, timely, and complete medication information) across the facility. After staff standardized processes, developed training videos, and updated the policy, the Patient Safety Manager noted medication error reports subsequently decreased. Staff explained they share ongoing improvement projects with facility staff during town halls.

The OIG determined whether primary care teams were staffed per VHA Directive 1406(2) and Handbook 1101.10(2) and received support from leaders.[28] The OIG interviewed staff, analyzed primary care team staffing data, and new patient appointment wait times.

Primary Care Teams

At the time of the OIG inspection in May 2025, the facility had 44 primary care teams. Primary care leaders provided documents that showed there were eight provider and two lead advanced medical support assistant vacancies. The Associate Chief of Staff for the Medicine Service said existing float staff (who cover for those on leave and vacant positions) and two long-term contracted providers supported the teams. Despite offering monetary incentives and educational debt assistance, the Chief of Staff explained it was a challenge to hire primary care physicians because it is a small facility that lacks surgical services, other types of specialty care, and affiliation with a local hospital that offers tertiary care.[29]

Additionally, primary care staff stated that frequent turnover in provider positions made it difficult to maintain continuity of care for patients. A primary care provider, who had been in the role for just over a year, said some providers decline positions while others start and leave quickly. The associate chief added that leaders were exploring options to have non-primary care providers and emergency medical services staff assist.

[27] A root cause analysis is a formal, "comprehensive team-based, systems-level investigation" for reviewing "health care adverse events and close calls." VHA Directive 1050.01(1).

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

[29] Tertiary care is "highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatment performed by medical specialists in state-of-the-art facilities." *Merriam Webster*, "Tertiary Care," accessed November 13, 2025, https://www.merriam-webster.com/dictionary/tertiary.

The OIG found the primary care team panels averaged 96 percent of VHA's recommended size for calendar year 2024.[30] According to staff, most panels were either close to being full or currently at capacity. Some panels had increased due to reassigned patients from providers who left. The facility's goal for panels was 85 percent of VHA's recommended size to allow leaders to plan and create new teams before panel sizes exceed 100 percent and staff become overburdened. As they fill provider positions, panel sizes will move toward this goal.

The OIG noted a 1.75 percent increase in veteran enrollment from FY 2022 through FY 2024. The OIG reviewed other data that showed appointment wait times were approximately 10 days for new patients and 4 days for existing patients in quarter one of FY 2025, which is better than the recommendation of 20 calendar days or less, as stated in VHA Directive 1231(4).[31]

Primary care staff stated they felt supported by their immediate leaders. The chief nurse of the Ambulatory Care Nursing Service said that, starting in January 2025, primary care leaders began visiting one clinic location each month to ask staff for feedback and document their suggestions and concerns. Leaders then reported on the follow-up actions during newly started quarterly primary care team town halls, which were also based on staff's suggestions. The OIG attended one of these town halls and witnessed an educational presentation, information sharing, and opportunities for staff to ask questions.

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 aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[32]

[30] Panel size is the number of patients assigned to a care team. "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). The baseline capacity for a full-time primary care team with a physician provider is 1,200 patients, depending on patient characteristics and level of clinic staff and administrative support. VHA Directive 1406(2).

[31] VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

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

VHA uses performance measures to determine the success of each facility's program. The first, HCHV5, measures the percentage of homeless veterans who receive a program intake assessment (performance measure HCHV5).[33] Next, HCHV1 measures the percentage of veterans who are discharged from contracted residential services and low-demand safe haven programs into permanent housing.[34] Finally, HCHV2 (negative exits) measures 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."[35]

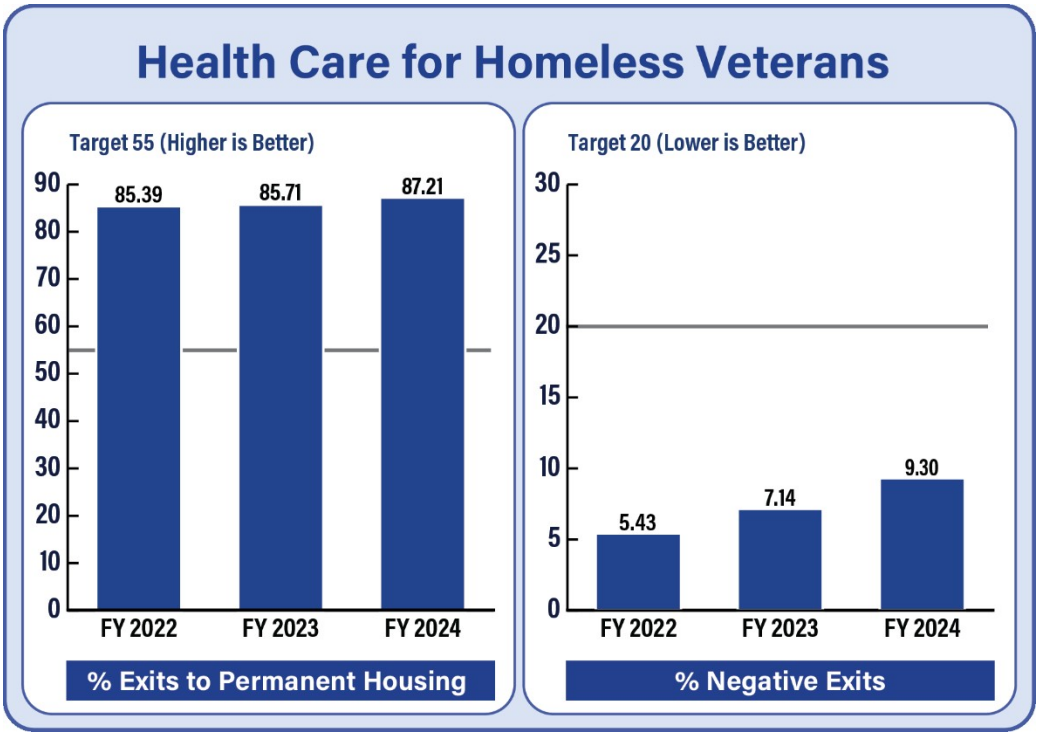

Figure 6. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

Program Highlights

- The program met the HCHV5 target in FYs 2023 and 2024, which a manager attributed to placing two staff members at each homeless clinic to meet with veterans who walk in for services. The program also exceeded both HCHV1 and

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

[34] Low-demand safe havens are transitional residences with minimal restrictions for veterans with mental health or substance use issues. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[35] 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*.

HCHV2 targets for FYs 2022 through 2024 and continued to meet them through quarter two of FY 2025.

- The manager also shared that staff in the HCHV, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Program receive cross-training and work as one team to ensure veterans receive continuity of care. The team proudly described their collaboration with Kent County, which in 2017 was the first county in Michigan to declare an end to veteran homelessness, followed by Lansing and Ingham counties.[36] A homeless program manager explained that once a veteran is identified as homeless, staff find housing for them in less than 90 days.

Housing and Urban Development–Veterans Affairs Supportive Housing

The Housing and Urban Development–Veterans Affairs Supportive Housing program combines Department of Housing and Urban Development rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including " serious mental illness, physical health diagnoses, and substance use disorders."[37] The program uses the housing first approach to prioritize rapid placement into housing followed by individualized services.[38]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[39]

A homeless program manager described a Marine who served in combat tours, later became unemployed, and contacted the homeless program. Staff assisted the veteran with immediate needs, offered treatment options, and continued to support work goals. The veteran successfully transitioned to permanent assistive housing about six months later. After receiving disability status, the veteran began part-time work and purchased a home.

Figure 7. *Veteran engagement. Source: OIG analysis of questionnaires.*

Program Highlights

- The program did not meet the HMLS3 target for FY 2022 through quarter two of FY°2025. A program manager identified a lack of affordable housing and

[36] "Ending Veteran Homelessness," Department of Veterans Affairs, accessed July 31, 2025, https://www.va.gov/endingVetshomelessness.asp.

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

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

[39] VHA sets the HMLS3 target at 90 percent or above and the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

properties that did not meet city inspection requirements as barriers to meeting the target. A homeless program manager explained some landlords had not maintained the properties and did not pass inspections, which resulted in fewer housing options. Program staff then had to find alternative options for affected veterans. The manager also said a public housing agency was unable to issue vouchers due to funding shortfalls, which was an additional barrier to meeting the target.

- The program met the VASH3 targets for FYs 2022 through 2024. A homeless program manager shared the team completes employment assessments, and the program's Community Employment Coordinator helps veterans find appropriate positions. The coordinator maintains working relationships with local businesses and encourages them to employ homeless veterans.

Veterans Justice Program

VHA's Veterans Justice Program serves veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration.[40] Recognizing incarceration as a strong predictor of homelessness, the program focuses on connecting veterans to VA health care, services, and benefits. VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[41]

Program Highlights

- The program exceeded the target since VHA initiated this metric in FY 2023.[42] A veterans justice outreach coordinator stated they focused on increasing program awareness among facility staff and community partners by educating them, promoting visibility, explaining how to reach program staff, and discussing available resources. Additionally, staff are increasing outreach at rural jails and prisons.

A Veterans Justice Program coordinator shared a success story about a veteran with repeat driving under the influence infractions who enrolled in the homeless program. The veteran was arrested in another county, and jail staff contacted the coordinator, who knew the veteran and arranged a transfer to a county with a veterans treatment court. The veteran completed the treatment court requirements, purchased a home, regained full driving privileges, and became an advocate for veterans treatment courts.

Figure 8. *Veteran engagement. Source: OIG analysis of questionnaires.*

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

[41] 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*.

[42] VHA sets escalating targets based on the number of the veterans entering the Veterans Justice Programs based on prior facility data. The metric is a percentage of that target, and program staff are able to exceed 100 percent.

- A veterans justice outreach coordinator reported staff meet monthly with veterans to discuss their needs and plans, such as parole dates, housing, and skills needed to successfully transition back into the community. After receiving permission to access prisons during the past year, the coordinator worked on improving communication with jail and prison staff, especially when a veteran's incarceration release date changes, which can disrupt plans for housing.

Conclusion

The OIG is aware of the transformation of 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 cleanliness and safety, medical equipment maintenance, repeat environment of care findings, and test result communication. Facility leaders implemented corrective actions, and the OIG closed all recommendations. 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.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. 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.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] 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 May 20 through 22, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

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

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

[3] 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.

[4] 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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

† 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 Photo

Figure C.1. *Example of stickers affixed to a piece of medical equipment.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 30, 2025

From: Interim Network Director, VA Healthcare System Serving Ohio, Indiana, and Michigan (10N10)

Subj: Healthcare Facility Inspection of the VA Battle Creek Healthcare System in Michigan

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

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to work with the Office of Inspector General's Office of Healthcare Inspections as we continuously strive to improve the quality of health care for the Nation's Veterans. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values.
2. I concur with the report findings and recommendations of OIG report, Healthcare Facility Inspection of the VA Battle Creek Healthcare System in Michigan.
3. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(Original signed by:)

Jill Dietrich Mellon, JD, MBA, FACHE

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: January 5, 2026

From: Acting Medical Center Director, VA Battle Creek Healthcare System (515)

Subj: Healthcare Facility Inspection of the VA Battle Creek Healthcare System in Michigan

To: Acting Network Director, VA Healthcare System Serving Ohio, Indiana, and Michigan

1. We appreciate the opportunity to review and comment on the Healthcare Facility Inspection of the Battle Creek VA Medical Center.
2. I concur with the recommendations and will take corrective action.
3. Should you need further information, please contact the Chief of Quality Management.

(Original signed by:)

Natasha Watson
Acting Medical Center Director
Battle Creek VA Medical Center

OIG Contact and Staff Acknowledgments

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