US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Dayton Healthcare System in Ohio

Healthcare Facility Inspection	25-00251-124	June 18, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Dayton Healthcare System (the facility) from August 11 through 14, 2025. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided care to approximately 46,000 veterans.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The facility had dirty floors and carpets and overflowing trash in a bathroom. The OIG made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated. The OIG made no recommendations.

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

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

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

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

What the OIG Recommended

1. The Director ensures Environmental Management Services staff keep patient care areas clean and well maintained.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[4] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[5]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[8]

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[4] "About VHA," VA, last updated January 20, 2025, https://www.va.gov/aboutvha.

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

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

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

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

The VA Dayton Healthcare System (the facility) includes a medical center in Dayton and five community-based outpatient clinics in Lima, Middletown, Springfield, and at the Wright-Patterson Air Force Base in Ohio; as well as in Richmond, Indiana.[9] In fiscal year (FY) 2025, the medical care budget was approximately $790 million. It had 91 inpatient hospital, 99 domiciliary, and 133 community living center beds, and served approximately 46,000 veterans.[10]

Figure 1. *Facility photo.*
Source: "VA Dayton Healthcare," VA, accessed September 7, 2025, https://www.va.gov/dayton-health-care/.

The OIG team inspected the facility from August 11 through 14, 2025. The executive leaders referred to throughout this report include the Medical Center Director (Director), Associate Medical Center Director, Chief of Staff, and Associate Director for Patient Care Services. The facility liaison provided documents that showed the executive leaders had been working together since November 2023.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and

[9] "About Us," VA, last updated August 15, 2025, https://www.va.gov/dayton-health-care; The facility has a sharing agreement with the Wright-Patterson Air Force Base, which expires in 2027.

[10] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," VA, last updated May 1, 2025, https://www.va.gov/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/VA_CLC. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated April 1, 2026, https://reports.vssc.med.va.gov/ReportServer/Pages/ReportViewer. (This web page is not publicly accessible.)

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

assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

System Shocks

In an interview, executive leaders identified the implementation of the new electronic health record, staffing, and construction as system shocks.

- The executive leaders said deployment of the new health record system at the facility was originally set for September 2023; however, it was postponed until June 2026. During this waiting period, they upgraded their information technology systems. They also identified new superusers who have begun to receive training and updated employees on the system through weekly messages, town halls, and service line workshops. The executive leaders also worked closely with employees from another VA medical center and the Wright-Patterson Air Force Base who have already implemented the new system to learn from their experiences.
- They discussed the hiring freeze and how it affected staffing levels as well.[14] They reported an inability to hire for some nonclinical positions, such as the vacant chief and other positions in the Environmental Management Service. To compensate, contract employees supplement the vacancies until they can hire. Further, leaders said purchasing agent positions in both prosthetics (providing devices that support or replace a body part or function) and supply chain were downgraded in salary, which caused some employees to resign and delayed noncritical prosthetic supply purchases. Therefore, they reassigned purchase agent employees from other VA medical centers within the Veterans Integrated Service Network (VISN) to meet the demand.[15]

[12] "Veteran Trust in VA," VA, last updated January 20, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

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

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

[15] "Rehabilitation and Prosthetic Services," VA, last updated October 24, 2024, https://www.prosthetics.va.gov/psas; Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," VA, last updated August 11, 2025, https://www.va.gov/visns.

- Various construction projects were highlighted and how they affect patients and employees. Leaders reported $180 million in active construction projects, which include upgrades to the electrical system and boiler plant (equipment and systems to generate and distribute steam and hot water), and a recently completed $8 million steam system upgrade.[16] In addition, leaders are renovating primary care and specialty care clinics. Part of the project will include a dedicated entrance to the women's clinic. Leaders noted that many of these projects involve repairs necessary to sustain operations.

Employee Experiences

Executive leaders said they demonstrated the high reliability organization pillars of leadership commitment, safety culture, and continuous improvement, as well as created a safe space for employees to provide feedback. Additionally, they implemented the Superhero award, which allows anyone to nominate someone who has incorporated the pillars into their work. They also acknowledge the work of their employees through town halls, safety forums, and awards. Leaders said they believed employees felt psychologically safe to report concerns because of the increase in patient safety reports, and that close calls outnumber actual incidents, which they said meant employees report potential problems before they occur.[17]

Executive leaders said they visit various units each week and participate in fireside chats and town halls to meet with employees and share information. They also reported visiting community-based outpatient clinics quarterly but not consistently. Therefore, they identified improving consistency with these visits as a goal for the next year. To foster service-line leaders' involvement, executive leaders stated they require service chiefs to visit their units weekly.

[16] VHA Directive 1810, *Boiler and Boiler Plant Operations*, January 4, 2023.

[17] "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.

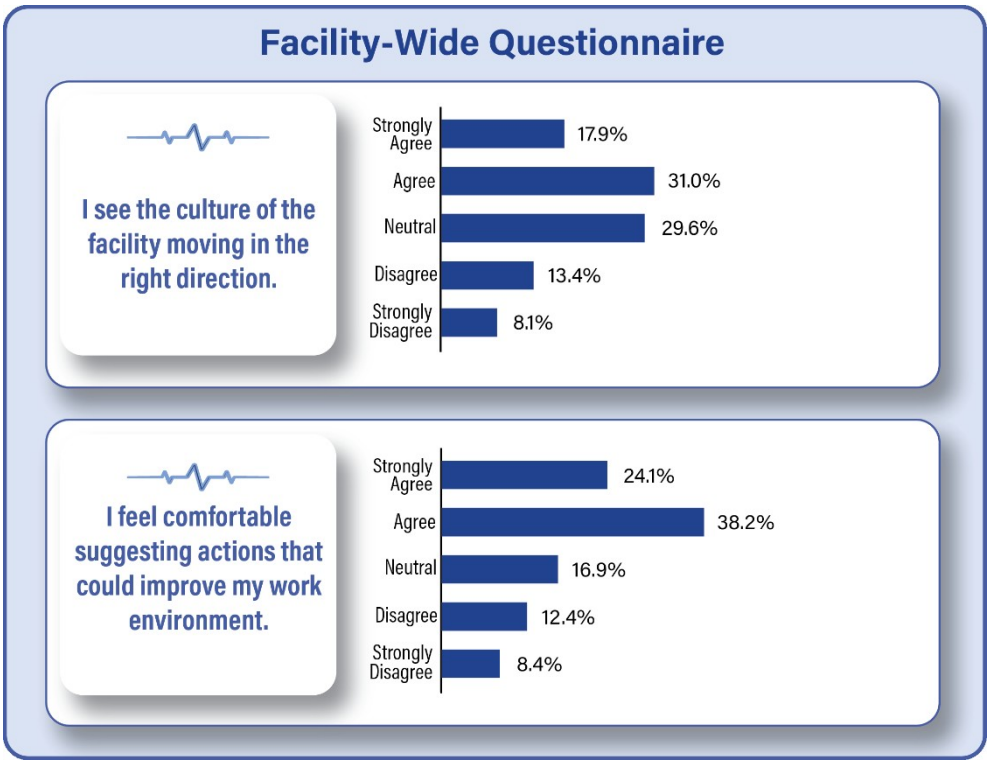

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

Executive leaders said they routinely meet with veterans service organizations and other community organizations to answer questions.[18] As a result, the American Legion donated $13,000 to the facility and hosts an annual fish fry, with all proceeds benefiting the facility. Leaders added that veteran trust scores are in the mid-90 percent range, suggesting they are pleased with the care and other services provided to them.

[18] "Veterans Service Organizations (VSOs) are organizations that aid and serve veterans, servicemembers, dependents, and survivors." Congressional Research Service, *Veterans Service Organizations (VSOs): Frequently Asked Questions*, updated February 6, 2024.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[19] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[20]

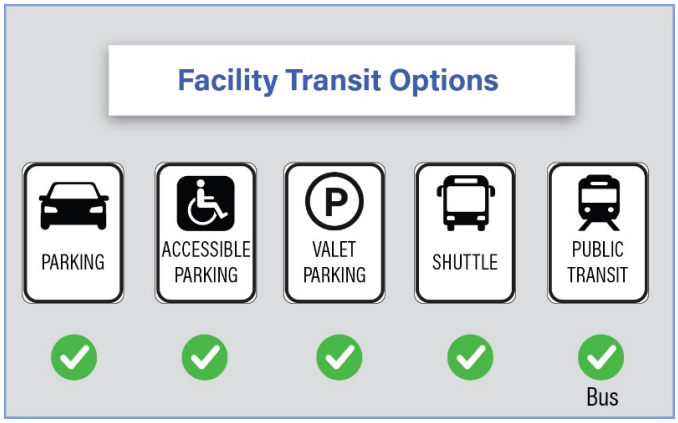

Figure 3. *Transit options for arriving at the facility. Source: Facility liaison questionnaire responses, facility maps, and shuttle schedule.*

General Inspection

The facility consisted of multiple buildings spread across an expansive area and had directional signs throughout the campus. The parking lots had ample parking spaces, lighting, security cameras, emergency call buttons, and police patrol. According to facility staff, a public bus stops directly in front of the main entrance; there are also valet and shuttle services to the parking lots.

At the main entrance, the OIG noted an atrium-style lobby that was clean and had natural and artificial lighting and minimal noise. Employees and volunteers managed a large information desk and provided maps, information, directions, and assistance as needed. An ample supply of wheelchairs and a vendor selling coffee, sandwiches, and snacks were nearby.

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

[20] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: Team observations, facility maps, facility liaison, OIG questionnaire responses, and a facility policy and procedure.

Based on documents and questionnaire responses, the OIG determined the facility provides tools and resources for hearing-impaired veterans, including hearing aids, personal amplifiers, communication boards, and amplified phones. The Visual Impairment Service Team (VIST) developed a pop-up window in the electronic health record, which alerts providers if the veteran has visual limitations. Additionally, staff indicated the Advanced Low Vision Clinic screens inpatient veterans who are visually impaired at the bedside to address their immediate needs for magnification devices, orientation, and mobility assistance.

The inspection team observed dirty floors and carpets in clean linen closets and supply and lactation rooms, as well as overflowing trash in a bathroom. When floors, carpets, and areas are not cleaned regularly, an accumulation of pathogens (bacteria or viruses), especially in high-traffic areas, can increase the risk of infection for veterans and employees who use those spaces. VHA Directive 1608(1), *Comprehensive Environment of Care Program,* requires all medical facilities to provide a "safe, clean and high-quality environment." Facility leaders attributed the lack of cleanliness to challenges with hiring housekeeping staff in the Environmental Management Services department, and it being without a chief and assistant chief. Leaders said they have been awarded a short-term contract to hire staff for additional support.

Recommendation 1

The Director ensures Environmental Management Services staff keep patient care areas clean and well maintained.

_X_ Concur

____ Nonconcur

Target date for completion: November 2026

Director Comments

The Medical Center Director acknowledges staffing shortages presented challenges in consistently meeting the expected cleanliness standards throughout patient care areas. The

Assistant Director and Acting Chief of Environmental Management Services (EMS) has taken proactive steps to address the deficiencies identified during the inspection. These actions include recognizing the underlying issues and securing a short-term contract to augment current staffing levels with additional housekeeping personnel. Recruitment is actively underway for the Chief position, along with six other leadership-support roles, to strengthen long-term operational stability.

To ensure ongoing improvement and sustained compliance, EMS leadership will utilize the Performance Logic rounding checklist on a monthly basis to evaluate high-traffic and critical areas such as clean linen closets, supply rooms, lactation rooms, and bathrooms. Identified deficiencies will be corrected within the established 14-business-day compliance window, with clear assignment of staff responsible for timely corrective action. Compliance data will be continuously monitored and tracked with a goal of achieving and maintaining at least 90 percent adherence over six consecutive months. Progress will be reported monthly to the Quality Patient Safety Board to maintain transparency and accountability.

In addition, EMS has incorporated departmental cleaning-compliance results into the Director's Morning Report. This ensures that facility leadership receives consistent, real-time visibility into environmental cleanliness performance, allowing prompt mitigation of emerging issues and reinforcing accountability for sustained improvement.

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

Communication of Urgent but Noncritical Test Results

The facility had a policy on test result communication, and workflows to outline the process for each service, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[21] The external peer review program coordinator discussed reviewing data for abnormal test result communication monthly with service chiefs and staff champions. The champions analyze the data, educate the care team on the findings, and report the data to various governing boards.

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

Action Plans and Process Improvements

There were no open recommendations from previous OIG comprehensive healthcare inspections. During the interview with executive leaders and quality management staff, the OIG learned that quality management staff routinely work with service leaders to develop action plans to address recommendations. Staff then track action plans and report on their status to several governance boards until staff complete the plans.

Executive leaders and quality management staff also discussed the various methods used to identify opportunities for improvement, including through the Joint Patient Safety Reporting system and patient safety forum discussions.[22] Quality management staff said they meet with executive leaders daily to discuss safety trends, and leaders discuss patient safety concerns during town halls, committee meetings, and visits to clinical areas.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[23] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The facility provided documents showing multiple vacancies within primary care including for providers, registered nurses, licensed practical nurses, and medical support assistants. Primary care leaders said the vacancies were due to retirements and transfers to other departments. To manage these vacancies, they rely on float providers, VISN clinical resource hub staff, and overtime.[24] The leaders said they have approval to hire staff, keep open announcements for providers, and are recruiting internally for nurses and medical support assistants. However,

[22] The Joint Patient Safety Reporting (JPSR) system is a database used as a collaborative tool for employees to document patient safety events including medical errors and close calls, and for the patient safety manager to track and trend reported events. VHA National Center for Patient Safety, *JPSR Guidebook*, *Version 6.0*, October 2025.

[23] "Community Care, About Us," VA, last updated August 5, 2024, https://www.va.gov/CommmunityCare; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[24] Clinical resource hubs "provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

ongoing construction within the primary care clinic, and the Presidential Memorandum requiring staff return to in-person work have limited the space available for new hires.[25]

Primary care leaders said multiple providers have panels (patients assigned to a care team) that exceed the baseline capacity of 1,200 patients, as recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, which they attributed to increased patient enrollment.[26] Therefore, they plan to open two new primary care teams, after the construction, and hope that will alleviate some of the burden on those providers. Despite the large panel sizes, leaders said that on average, a new patient can be seen within nine days and an established patient within three days.

Community Care Staffing and Access to Care

The OIG found that program staff scheduled community care appointments on an average of 10 days from when they received the consults. According to VHA's *Consult Timeliness Standard Operating Procedure*, staff must schedule appointments for patients within 7 days.[27] In response to an OIG-administered questionnaire, staff indicated that delays resulted from an increase in community care consults and limited appointment availability in the community. A community care leader added that if a patient is not available to receive a scheduling call, community care staff send a letter advising the patient to call back within 14 days, which differs from the 7-day requirement.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader

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

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

[27] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," July 8, 2024.

life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[28]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[29] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[30] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[31]

Performance and Improvement Highlights

- At the time of the inspection in August 2025, the facility's program was meeting the discharge to permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2025. The facility has a 15-bed contract with a local community shelter, and facility program staff collaborate with other shelters and community partners to secure emergency housing.
- Staff cited positive feedback from veterans, anonymous satisfaction surveys, and success stories of veterans being housed and doing well. They felt supported by both executive and mid-level leaders and highlighted the Director's active involvement in community events.

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

[29] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures,* November 2024.

[30] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*; Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

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

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[32] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[33]

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).[34]

Performance and Improvement Highlights

- The facility's program was on track to meet the voucher use (HMLS3) and employment (VASH3) targets for enrolled veterans in FY 2025. Facility program staff attributed the success to the facility's smaller size and the team's communication and cohesion. Program leaders said they have 236 housing vouchers and 217 veterans currently housed.
- Staff said they work closely with several community partners such as the public housing authorities and Tunnel to Towers Foundation.[35] Staff host outreach events to identify veterans and, through the help of community partners, secure temporary housing for them.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[36] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care,

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

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

[34] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

[35] Tunnel to Towers Foundation provides "mortgage-free homes to Gold Star and fallen first responder families with young children and by building specially-adapted smart homes for catastrophically injured veterans and first responders." "About Us," Tunnel to Towers Foundation, accessed September 17, 2025, https://t2t.org/.

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

services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[37]

Performance and Improvement Highlights

- The facility's program was on track to meet the enrollment (VJP1) target for FY 2025. Facility program staff identified several strengths, including effective communication and strong relationships with community partners and facility providers. They also said veterans often speak positively about the program, which enhances its reputation in the community.
- Staff said program specialists visit local jails and prisons; attend veterans treatment courts; collaborate with facility providers and community partners; and refer veterans for services such as housing, health care, and mental health treatment.[38] In addition, staff educate community partners and local law enforcement about deflection strategies to connect veterans to voluntary treatment and support services and direct them away from being arrested or involuntarily committed.
- Staff also said the facility partners with legal aid programs to provide free civil legal services to veterans. One of the programs received a grant that funds attorney availability at the facility twice a week. In addition, a local law school offers legal services to veterans during the academic year and escorts veterans to court when needed.

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

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

Conclusion

To assist leaders in evaluating the quality of care at the Dayton facility, the OIG conducted an inspection across five domains. The OIG made one recommendation related to the facility's cleanliness. The single recommendation does not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendation may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[39] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[40] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation*, *Governance, and Public Trust*.[41]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[42] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The team inspected the facility from August 11 through 14, 2025. During site visits, the team

[39] The accreditation reports covered the time frame of October 1, 2022, through September 30, 2024—the most recent available at the time of the inspection.

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

[41] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[42] 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.

refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[43] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The OIG conducted the inspection in accordance with OIG procedures and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 19, 2026

From: Interim Network Director, Department of Veterans Affairs (VA) Healthcare System (10N10)

Subj: VA OIG DRAFT REPORT: Healthcare Facility Inspection of the VA Dayton Healthcare System in Ohio (MCI# 2025-00251-HI-1514)

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

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. I concur with the report findings and recommendations of OIG draft report—Healthcare Facility Inspection of the Dayton Healthcare System in Ohio.
2. I have reviewed the documentation and concur with the response as submitted.
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 C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 19, 2026

From: Director, VA Dayton Healthcare System (552)

Subj: Healthcare Facility Inspection of the VA Dayton Healthcare System in Ohio

To: Director, Veterans Integrated Service Network (10N10)

1. I appreciate the opportunity to review and comment on the Healthcare Facility Inspection report of the VA Dayton Healthcare System that was conducted August 11 through 14, 2025.
2. I concur with the recommendation and have taken corrective actions.
3. Should you need further information, please contact the Chief of Quality and Patient Safety Service.

(Original signed by:)

Jennifer Defrancesco, DHA, FACHE

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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.