



US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Columbia Missouri Healthcare System

Healthcare Facility
Inspection

26-00046-284

October 5, 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 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 Columbia Missouri Healthcare System (the facility) from February 10 through 12, 2026. The OIG received additional updates from the facility in April and July 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 44,000 patients.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 OIG team observed dusty equipment and surfaces in several clinical areas which did not comply with VHA Directive 1608(1), *Comprehensive Environment of Care Program*.³ In response, the OIG made a recommendation for corrective action.
- **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.⁴ The OIG made no recommendations.

¹ VHA classifies facilities based on their complexity level. 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, updated February 4, 2026, <https://reports.vssc.med.va.gov>. (This web page is not publicly accessible.) "VHA Station Listing," VHA Support Service Center, accessed March 9, 2026, <https://reports.vssc.med.va.gov>. (This web page is not publicly accessible.)

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

³ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

⁴ 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.

- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. Facility leaders take appropriate actions so staff maintain a safe and clean environment, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C for the full text of the directors' comments).⁵ The OIG will follow up on the planned actions until they are completed.



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⁵ In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>.

Abbreviations

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

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Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.⁶ 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.⁷



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.⁸



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.⁹



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.¹⁰

⁶ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁷ 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>.

⁸ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

⁹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹⁰ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA Columbia Missouri Healthcare System (the facility) includes the Harry S. Truman Memorial Veterans' Hospital and nine community-based outpatient clinics. The facility's fiscal year (FY) 2025 budget was approximately \$430.7 million. It had 81 hospital, 14 community living center, 14 domiciliary, and 8 compensated work therapy/transitional residence beds.¹¹

The OIG team inspected the facility from February 10 through 12, 2026, and received additional updates in April and July 2026. The executive leaders referred to throughout this report include the Medical Center Director (Director), Chief of Staff, Associate Director, Assistant Director, Associate Director for Patient Care Services (Nurse Executive), and Executive of High Reliability.



Figure 1. Facility photo.

Source: "VA Columbia Missouri Health Care," VA, accessed January 30, 2026, <https://www.va.gov/columbia-missouri-health-care>.



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.¹² 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

¹¹ A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, <https://department.va.gov/homeless/dchv>. Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, last updated June 15, 2026, <https://department.va.gov/vha/cwt>. VA, *Facility Trip Pack (VISN [Veterans Integrated Service Network] 15) Harry S. Truman Memorial Veterans' Hospital*, last updated September 22, 2025.

¹² 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).¹³ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.¹⁴

System Shocks

Executive leaders and most employee respondents to the OIG questionnaire cited leadership turnover as a system shock.¹⁵ Leaders also identified the return to in-person work requirement, deferred resignation program, hiring freeze (in effect from January 20, 2025, to October 15, 2025), and the government efficiency order (which resulted in the termination of a supply chain management contract), as system shocks that disrupted operations and weakened employee retention and recruitment.¹⁶

During interviews, executive leaders told the OIG that four of the six team members had transitioned from acting to permanent roles since 2024, following the resignation of their predecessors or their transfer to other VA facilities. The Director, Chief of Staff, Associate Director, and Assistant Director transitioned to permanent roles, and the Nurse Executive and Executive of High Reliability remained unchanged. Although new to the position, the Associate Director reported working at the facility previously and understanding the organizational structure.

Executive leaders explained that the in-person work requirement caused challenges in allocating space and managing requests for reasonable accommodations (workplace modifications to enable individuals with disabilities to perform essential job functions).¹⁷ Leaders said the rush to assign space without knowing which staff would receive an accommodation created confusion.

¹³ “Veteran Trust in VA,” VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁴ Patient advocates are employees who receive feedback from veterans and help resolve their concerns. “Veterans Health Administration, 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.

¹⁵ The facility had 1,796 employees; 240 of them responded to the OIG questionnaire.

¹⁶ Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); VHA placed full-time employees who accepted the deferred resignation program into paid administrative leave until September 30, 2025, unless they were eligible to retire earlier. Acting Director, Office of Personnel Management, “Guidance Regarding Deferred Resignation Program,” memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025. Implementing the President’s “Department of Government Efficiency” Cost Efficiency Initiative, 90 Fed. Reg. 11095 (Mar. 3, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted “positions critical to delivering care to Veterans in” VHA. Acting Secretary, “Hiring Freeze Guidance,” memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), “Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675),” memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

¹⁷ “Reasonable Accommodations in the Workplace,” ADA [Americans with Disabilities Act] National Network, accessed June 22, 2026, <https://adata.org/factsheet/reasonable-accommodations-workplace>.

The executive leaders also stated that 24 employees left during the deferred resignation program, including 2 supply technicians. The inability to fill the vacant positions during the hiring freeze, combined with the terminated supply management contract, which had provided approximately 10 supply technicians, significantly disrupted supply operations. In response, leaders reassigned employees with prior supply chain experience, cross-trained employees from other areas, and authorized overtime to maintain operations.

Executive leaders further described physician retention and recruitment challenges due to higher salaries offered by community employers, delays in hiring, and the uncertainty about federal job security. To address clinical vacancies, leaders used physician contracts (temporary employment arrangements) and referred patients to community care and the Veterans Integrated Service Network (VISN) Clinical Resource Hub (which provides access to clinical services when local facilities have limited capabilities) when needed.¹⁸

The OIG team learned that to improve transparency and mitigate the effects of these shocks, executive leaders held more frequent town halls and distributed information to employees with questions and answers about the changes. The Executive of High Reliability said executive leaders also increased rounding (visits to workspaces), spoke with employees about their concerns, and made themselves more accessible.

Employee Experiences

Responses to the OIG questionnaire indicated that executive leader communications were clear, useful, and frequent. To promote transparency, executive leaders said they invited questions, acknowledged they did not have all the information employees wanted, and shared updates as soon as they became available. They explained that the facility culture is built on high reliability organization principles, where employees participate in process improvement activities and

¹⁸ VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). “Veterans Integrated Services Networks,” VA, last updated July 28, 2025, <https://department.va.gov/visns>. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG’s inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit <https://digital.va.gov/rise>. VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393. “Clinical Resource Hubs (CRH),” VA, last updated March 20, 2024, <https://www.patientcare.va.gov/CRH>.

facility leaders routinely visit employee work areas to identify concerns and implement corrective actions.¹⁹

Veteran Experiences

The facility's VSignals outpatient trust scores consistently exceeded VHA's national averages of 94 percent for the first three quarters of FY 2025, and veterans reported more compliments than complaints throughout FY 2025. Patient advocates stated that veterans' top concerns included delays in travel reimbursements and community care billing.

Executive leaders explained that vacancies in travel assistant positions negatively affected travel claim reimbursements from 2025 through February 2026, which caused backlogs, extended processing times, and increased veteran dissatisfaction. The facility had only one travel assistant due to employees leaving and difficulties filling the positions. The Associate Director said leaders did not initially prioritize hiring for the two vacant positions because of a planned consolidation of travel claims processing from facilities to the national Veterans Transportation Program Office; however, the plan was delayed.²⁰

To reduce travel reimbursement delays while waiting for the consolidation, executive leaders said the administrative officer of the day processed current claims, and two other VHA facilities were helping to clear the backlog. The Associate Director reported hiring a second travel assistant in February 2026 and requesting approval to recruit another at a higher salary to be more competitive with the community.

To address community care billing concerns, executive leaders assigned a community care representative—who could review payment authorizations and claim status—to an office near the patient advocates to help veterans navigate the claims process. The Director reported meeting regularly with patient advocates to discuss veterans' concerns and emerging trends.

¹⁹ “At the core of an HRO [high reliability organization] is a culture of ‘collective mindfulness,’ in which all workers look for, and report small problems or unsafe conditions before they pose a substantial risk to the organization.” “Evidence Brief: Implementation of High Reliability Organization Principles,” *VA Health Systems Research Management Brief* 157 (July 2019), https://www.hsrd.research.va.gov/publications/management_briefs.

²⁰ The Beneficiary Travel Program reimburses eligible veterans for travel costs to and from VA healthcare facilities. “Veterans Transportation Program (VTP),” VA, accessed July 1, 2026, <https://department.va.gov/vtp>.



ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.²¹ 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 the Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.²²

General Inspection

A bus stop is located close to the medical center, and the chief of engineering told the OIG team that volunteers provide shuttle transportation for veterans from the parking garage to the main entrance. The parking garage had sufficient lighting, emergency callboxes, and accessible spots for those with disabilities; a parking lot near the main entrance also had accessible spaces.

The main entrance had a passenger loading zone and a covered path from the parking garage. Signs in the lobby identified locations throughout the facility, and inspectors found the facility easy to navigate. Greeters said they used wheelchairs and escorts to help veterans reach their destinations safely, if needed. The lobby was well-lit, inviting, and had plenty of seating.

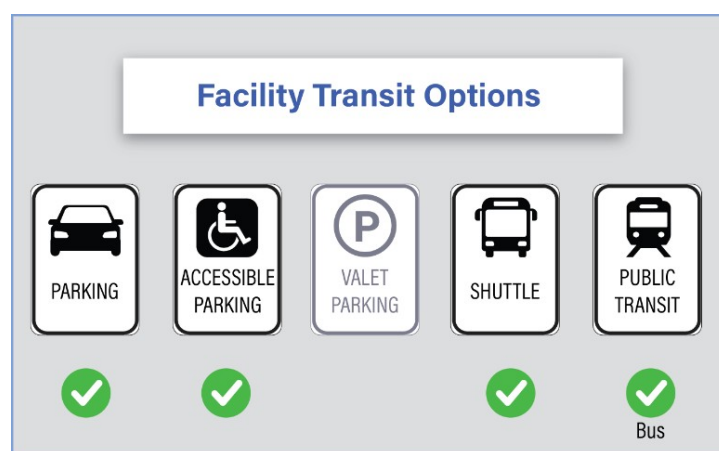


Figure 2. Transit options for arriving at the facility.

Source: OIG observations, interview with the chief of engineering, parking map, and description of shuttle services provided by the chief of development and civic engagement.

²¹ "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²² 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.

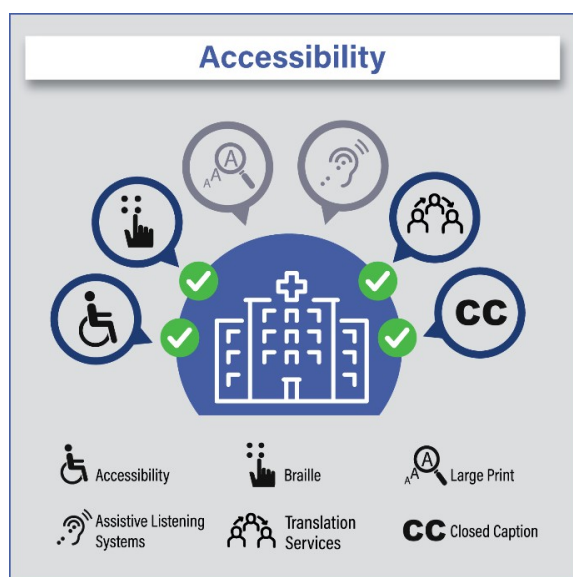


Figure 3. Accessibility tools available to veterans with impairments.

Source: OIG observations and interviews with main entrance volunteers and the chief of quality and patient safety.

However, inspectors identified multiple areas that required cleaning and maintenance. The team observed dust on surfaces in the emergency department, a medical-surgical unit, the intensive care unit, and multiple primary care clinics. The dust was on medical equipment, shelves, floors, and wall cabinets.

The emergency department nurse manager and the chief of environmental management services reported they were unsure which department was responsible for cleaning medical equipment; the nurse manager added that nurses could not assist with dusting because they did not have access to the supplies. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires staff to maintain a clean environment. Unclear responsibilities among staff affected cleanliness practices across multiple clinical areas and showed the need for facility leaders to ensure a safe and sanitary environment.

The chief of quality management provided an update in April 2026 and explained that staff who use the medical equipment were responsible for cleaning it, and environmental management services staff were responsible for dusting. The quality management chief updated the OIG again in July 2026 and reported that additional environmental management services staff were needed to ensure sustained cleaning practices, and position approvals were pending facility leaders' review. The OIG made a recommendation because facility leaders are still implementing corrective actions.

Recommendation 1

Facility leaders take appropriate actions so staff maintain a safe and clean environment, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

☒ Concur

☐ Nonconcur

Target date for completion: April 30, 2027

Director Comments

- a. Frontline supervisor monitoring of cleanliness has been ongoing since the Office of Inspector General (OIG) team's exit from the facility, with particular emphasis on the Emergency Department, primary care clinics, medical-surgical units, and the Intensive Care Unit, to maintain oversight while a comprehensive review of current processes and subsequent formal audit processes were established.
 - b. An interdisciplinary workgroup, established March 23, 2026 and led by the Assistant Director, was formed to evaluate gaps affecting the ability to sustain cleaning practices over time, including staffing vacancies in Environmental Management Service (the department responsible for facility cleaning), unclear responsibility for cleaning equipment that does not directly contact patients, and a cleaning process for equipment such as IV (intravenous) poles that was not sustainable given available staff.
 - c. A new written procedure, signed June 17, 2026, was developed by a separate tertiary storage workgroup covering management of long-term supply storage areas. This procedure addressed first-in, first-out supply rotation (using older supplies before newer ones to prevent expiration) as well as cleanliness expectations for cabinets, shelves, drawers, and other storage locations, which had not previously been addressed by any existing written procedure. The facility's Infection Control Nurse completed a risk assessment on July 16, 2026, to safely simplify the cleaning process for IV poles while following the manufacturer's cleaning instructions. On July 1, 2026, a searchable database of equipment cleaning instructions for end users was made available on the Resource Management Department's SharePoint site, along with a similar searchable database in OneSource for holders of Equipment Inventory Listing (EIL) items.
 - d. A request for additional intermittent Environmental Management Service positions, to handle lower-risk cleaning tasks such as trash removal and dusting, was approved by the medical center's Resource Management Committee on August 10, 2026. Recruitment incentives were also approved to attract more applicants and improve retention of Environmental Management Service staff, and the Chief of Environmental Management Service added a third-shift staff position dedicated to the Emergency Department to address staffing needs identified in that area. A written procedure covering cleaning of all non-clinical equipment, other than Alaris infusion pumps, was signed August 26, 2026. A separate written procedure, signed August 31, 2026, was developed for cleaning the Alaris infusion system (a device used to deliver IV medications and fluids), reflecting the simplified process identified through the infection control risk assessment.
 - e. Through ongoing frontline monitoring, supervisors in the Emergency Department repeatedly observed that dust returned quickly even after staff had recently cleaned the
-

area. After this pattern recurred over time, Facilities Management was notified to investigate a possible underlying cause. That investigation determined the air ducts needed cleaning, and this service was requested and scheduled with an outside contractor for September 8, 2026.

- f. A formal, standardized audit process to check cleanliness of storage areas, equipment, and the general environment will begin October 1, 2026, with results reported to facility leadership beginning November 2026. Results will be reviewed by the Infection Control Committee, the Healthcare Operations Board, and the Nurse Executive Board to ensure continued oversight and prompt correction of any problems identified. Facility leaders will continue this monitoring until all three audit areas show 90 percent compliance with cleanliness standards, sustained for six consecutive months.



PATIENT SAFETY

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

Communication of Urgent but Noncritical Test Results

The OIG team found the facility had policies and processes consistent with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, which requires staff to notify patients within seven days for abnormal test results that require follow-up, monitor communication timeliness, and develop service-level workflows that define staff members' roles in the process for communicating urgent but noncritical results.²³

Action Plans and Process Improvements

Patient safety managers stated they trained staff on expectations for patient safety reporting, provided feedback to those who disclose events, and informed all facility staff of patient safety improvement activities. Additionally, inpatient unit staff created poster boards displaying unit-specific safety metrics (for example, patient falls) to promote transparency and continuous awareness among frontline staff.

²³ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

In 2024, facility staff performed a risk assessment in response to 26 patient safety events involving the communication of test results that required action or events that were close calls (which could result in patient harm but did not).²⁴ The assessment resulted in seven action items related to

- supervising physicians not being included on resident physician (physician in training) medical orders and not receiving test results;
- primary care providers not being included on medical orders when their patients were treated as inpatients, in the emergency department, or by specialty care providers, and not receiving test results;
- the frequency of resident physician turnover;
- too many view alerts (notifications, such as test results, in the electronic health record system);
- lack of provider follow-up on biopsy results; and
- staff not uploading results into medical records.²⁵

During the inspection in February 2026, the OIG team asked about the status of corrective actions resulting from the assessment. Facility documents showed that staff had completed two of the seven action items—addressing the lack of follow-up on biopsy results by providers and ensuring primary care providers received the results of tests ordered for their patients when treated as inpatients, in the emergency department, or by specialty care providers.

The patient safety manager reported that staff who conducted the assessment attributed the lack of biopsy follow-up to delays in facility staff uploading images into the electronic health record. To address this issue, staff instructed providers who order biopsies to set reminders in patients' electronic health records to monitor the status of results. According to the chief of quality management, no staff have reported related patient safety events since the improvement action.

As follow-up to the on-site inspection, the OIG inquired about the status of the remaining action items from the 2024 risk assessment. According to a July 2026 update from the quality management chief, staff have completed all action items.

²⁴ VHA National Center for Patient Safety (NCPS), *Healthcare Failure Modes and Effects Analysis (HFMEA) Guidebook*, January 2021, <https://www.patientsafety.va.gov/HFMEA-Guidebook-January2021>.

²⁵ Truman VA, *Healthcare Failure Mode and Effect Analysis: Communication of Test Results*, October 1, 2024.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.²⁶ 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 offered primary care services through 44 primary care teams at 10 sites. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* recommends that each primary care team have at least three support staff assigned for every provider.²⁷ As of February 2026, the primary care operations manager reported a total of 21 vacant positions, including 9 providers, resulting in 5 teams with fewer staff than the recommended ratio. The OIG found that as of February 2026, primary care leaders had selected one provider, one registered nurse, one licensed practical nurse, and one medical support assistant to fill vacancies, but slow recruitment processes delayed hiring efforts. Additionally, staff explained that two physician positions had been vacant for more than 18 months because no qualified candidates applied. The deputy chief of staff said recruiting was difficult because most of the facility's outpatient clinics were rural and in healthcare deserts (areas of unmet healthcare needs due to lack of access to care or lower quality of health care).²⁸

Primary care staff reported that increased workload and burnout caused providers to consider resigning from VA employment. The staff also shared that providers treated patients admitted to the medical center on weekends to supplement inpatient provider staffing, and they did not have scheduled time off afterward other than using their own personal leave.

The OIG determined that seven provider panels (the patients assigned to a team) exceeded the size recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* (1,200 patients for physicians and 900 for nonphysician providers); four ranged from 119 to 185 percent of the recommended size, and three were at 100–110 percent.²⁹ Despite the large panels, the OIG found that average new and established patient appointment

²⁶ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>.

²⁷ VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

²⁸ Monica G Brinzac et al., "Defining Medical Deserts—an International Consensus-Building Exercise," *European Journal of Public Health* 33, no. 5 (October 2023): 785–788, <https://doi.org/10.1093/eurpub/ckad107>.

²⁹ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

wait times for the first three quarters of FY 2025 remained less than 20 days (the Code of Federal Regulations, title 38, section 17.4040 states that patients may be referred to community providers if the wait time is more than 20 days).³⁰ The Chief of Staff credited using the Clinical Resource Hub to decrease appointment wait times and maintain access at rural clinics.

Community Care Staffing and Access to Care

At the time of the inspection in February 2026, the community care chief reported three vacancies: one licensed practical nurse, one medical support assistant, and one advanced medical support assistant. Community care leaders noted the number of community care referrals increased by 6 percent in FY 2025 to an average of 6,000 per month. The chief of health administration services said only one person was available to scan medical records from community providers due to employee departures and the hiring freeze. This caused a scanning backlog that delayed facility providers' access to patient information. To eliminate the backlog, the chief said staff from the community care department scanned records; they also used overtime and a contract for scanning services. The OIG did not make a recommendation because at the time of the site visit in February 2026, the facility had taken corrective actions and reported no scanning backlog.

For the first quarter of FY 2026, the OIG found that most patients who met community care wait-time eligibility criteria needed radiology services and dental care because the facility's appointment wait time for these services was over 28 days.³¹ VHA's *Consult Timeliness Standard Operating Procedure* requires community care staff to schedule the appointment within 7 days of referral entry into the patient's electronic health record.³² Community care staff took an average of 5 days to schedule appointments for radiology services and 10 days for dental care. However, due to availability of community providers, patients on average waited 14 days for radiology services and 31 days for dental care in the community.

³⁰ 38 C.F.R. § 17.4040 (2025).

³¹ VHA Office of Community Care, "Veteran Community Care General Information" (fact sheet), September 9, 2019.

³² VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.



VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VHA or community-based residential programs for specialized treatment.³³

VHA uses performance measures to determine the success of each medical facility’s program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).³⁴ HCHV2 measures the percentage of veterans who are discharged from the program’s contracted emergency residential services or low-demand safe haven beds due to a “violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits).”³⁵

Performance and Improvement Highlights

- The facility’s program exceeded the target for exits to permanent housing (HCHV1) in FY 2025. The homeless program supervisor attributed the success to coordination with the HUD-VASH program, increased voucher use, improved referral processes, collaboration with a community partner, and strong relationships with local public housing agencies that helped identify housing options.

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

³⁴ VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. 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 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

³⁵ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Additionally, the contract residential services liaison met weekly with contracted emergency residential services staff to discuss enrolled veterans' housing plans.

- The program remained below the target for negative exits (HCHV2) in FY 2025. The homeless program supervisor credited this performance to staff proactively treating veterans' mental health or substance use problems that could affect placement and frequently communicating with veterans about program expectations and behaviors that could disrupt placement.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VHA case management services to support veterans who face significant barriers to stable housing, including “serious mental illness, physical health diagnoses, and substance use disorders.”³⁶ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³⁷

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).³⁸

Performance and Improvement Highlights

- The facility's program met the target for voucher use (HMLS3) for FY 2025. The homeless program supervisor connected the improvement to the same factors described in the HCHV program, as well as positive relationships with local landlords. The supervisor shared that the program provides landlords with an appreciation certificate for their willingness to rent to veterans.
- The program exceeded the employment target (VASH3) for FY 2025. According to the supervisor, this success was due to staff accurately recording employment data in the program database, as well as a community employment specialist who helps

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

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

³⁸ 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*.

veterans obtain employment. Program staff also refer veterans to the facility's vocational rehabilitation team to help them prepare for employment.³⁹

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.⁴⁰ Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).⁴¹

Performance and Improvement Highlights

- The facility met the target for the number of veterans entering the program (VJP1) in FY 2025. The homeless program supervisor credited this success to meeting with veterans in correctional facilities and enrolling them in the program.
- At the time of the February 2026 inspection, the supervisor reported 34 veterans were participating in veterans treatment court; 17 veterans had graduated in FY 2024 and 33 in FY 2025.⁴² Facility program staff explained that when a veteran successfully completed the program, their charges could be dismissed or lowered, which removed barriers to housing and employment.

³⁹ Vocational rehabilitation services include “help with job training, education, employment accommodations, resume development, and job seeking skills coaching.” “Veteran Readiness and Employment (VR&E),” VA, accessed February 26, 2026, <https://www.benefits.va.gov/vocrehab>.

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 enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁴² 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 VA Columbia Missouri Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to maintaining a safe and clean environment. The OIG's finding 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 team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.⁴³ 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 from February 10 through 12, 2026, and received additional updates in April and July 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG’s hotline management personnel for further review.

The inspection team’s analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency’s standards.⁴⁴ 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*.⁴⁵

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.⁴⁶ 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.

⁴³ The accreditation reports covered the time frame of October 1, 2023, through November 30, 2025—the most recent available at the time of the inspection.

⁴⁴ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁴⁵ 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.

⁴⁶ Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants “give inaccurate answers for a variety of reasons.” Dirk M. Elston, “Participation Bias, Self-Selection Bias, and Response Bias,” *Journal of American Academy of Dermatology* (2021): 1-2, <https://doi.org/10.1016/j.jaad.2021.06.025>.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.⁴⁷ 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.

⁴⁷ 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: September 10, 2026

From: Director, Department of Veterans Affairs (VA) Heartland Network (10N15)

Subj: Healthcare Facility Inspection of the VA Columbia Missouri Healthcare System (589A4)

To: Director, Office of Healthcare Inspections (54HF04)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the Healthcare Facility Inspection of the VA Columbia Missouri Healthcare System. I reviewed the documentation and concur with the submitted response.
2. Should you need any further information, contact the Veterans Integrated Services Network Quality Manager.

(Original signed by:)

Ahmad Batrash, MD, FACP
VISN 15 Interim Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 2, 2026

From: Director, VA Columbia Missouri Healthcare System (589A4)

Subj: Healthcare Facility Inspection of the VA Columbia Missouri Healthcare System

To: Director, VA Heart of America Health Network (10N4)

1. We appreciate the opportunity to work with the OIG'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 the OIG report.
2. Columbia Missouri VA Health Care System concurs with the findings and is taking actions as recommended.
3. Should you need further information, contact the Chief of Quality Management.

(Original signed by:)

Paul F. Hopkins, MBA
Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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Director, VA Columbia Missouri Healthcare System (589A4)

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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.