US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Salt Lake City Healthcare System in Utah

Healthcare Facility Inspection	26-00685-08	October 29, 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 Salt Lake City Healthcare System (the facility) from April 20 through 23, 2026, and followed up with facility staff in August 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 82,000 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 team found a lack of trust and psychological safety (a shared belief that it is safe to take risks within an organization) between some employees and the executive leadership team, contrary to principles in the *Veterans Health Administration High Reliability Organization (HRO) Reference Guide*.[3] Therefore, the OIG made a recommendation to the Veterans Integrated Service Network Director.[4]
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "Trip Pack – Operational Statistics Table FY2026 Through March," VHA Support Service center, last updated April 8, 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] VA, *VHA High Reliability Organization (HRO) Reference Guide*, September 2024.

[4] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, 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.

- **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.[5] 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 have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Veterans Integrated Service Network Director takes action so that executive leaders establish trust and a culture of safety, in accordance with the *Veterans Health Administration High Reliability Organization (HRO) Reference Guide*.

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). The OIG will follow up on the planned actions until they are completed.



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[5] 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.

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]

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[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 Salt Lake City Healthcare System (the facility) serves veterans at 11 locations in Utah, Idaho, and Nevada. It includes the George E. Wahlen VA Medical Center in Salt Lake City and 10 community-based outpatient clinics in North Logan, Orem, Price, Roosevelt, South Jordan, South Ogden, and St. George, Utah; Idaho Falls and Pocatello, Idaho; and Elko, Nevada.[11] In fiscal year (FY) 2025, the facility had a medical care budget of more than $1 billion, operated 70 inpatient hospital and 30 domiciliary beds, and served about 82,000 veterans.[12]

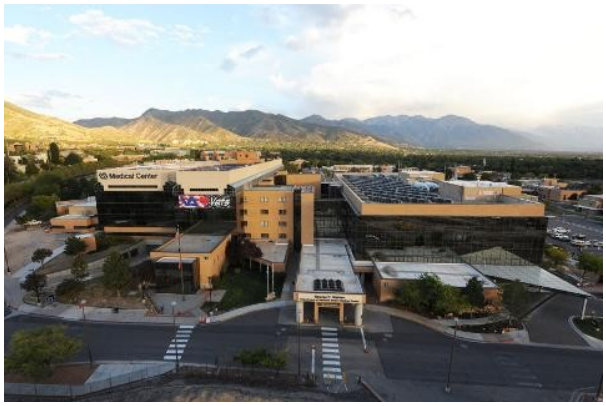


Figure 1. *Facility photo.*
Source: "VA Salt Lake City Health Care," VA, accessed April 8, 2026, https://www.va.gov/salt-lake-city-health-care.

The OIG team inspected the facility from April 20 through 23, 2026, and followed up with staff in August 2026. The executive leaders referred to throughout this report include the Executive Director (Director), Associate Director, Associate Director of Patient Care Services, Chief of Staff, and Assistant Director.

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.[13] 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 assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

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[11] "VA Salt Lake City Health Care," VA, accessed April 8, 2026, https://www.va.gov/salt-lake-city-health-care.

[12] 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. "Trip Pack – Operational Statistics Table FY2026 Through March," VHA Support Service center, last updated April 8, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible.)

[13] 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.

[14] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[15] 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/HEALTH/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

System Shocks

During an interview, executive leaders identified three system shocks: a flood in the medical center, changes to employees' work schedules, and budget limits that required them to eliminate vacant positions. The leaders reported a large pipe burst in August 2024, flooding three patient care areas and one administrative location. The damage immediately disrupted clinical operations and threatened continuity of care for veterans who rely on timely access to services.

In response, leaders canceled some outpatient clinics while employees contacted veterans to explain the situation, reschedule appointments, or refer them to community care to prevent delays in treatment.[16] To maintain services, leaders set up temporary buildings and relocated other clinics within the facility. Employees supported these changes by escorting or directing veterans to their destinations with the help of volunteers, posting clear signs, and establishing new parking areas. Leaders also created a website to give employees real-time updates, which helped maintain coordination and minimize confusion. Despite the disruption, leaders said employees remained understanding, helpful, and resilient. As of August 2026, repairs in most spaces had been completed.

Executive leaders also described how the changes to work schedules affected both operations and access to care. In 2024, many employees worked 10-hour days to meet the required 80 hours per pay period in eight workdays. Leaders said they found that this schedule reduced appointment availability, limited access to care, and decreased overall productivity, which created operational challenges for the facility.

In 2025, leaders met with each service to explain the need for modifications and allowed service leaders to submit justifications to keep the 10-hour schedule. After negotiations, leaders adopted a 5/4-9 schedule (in which employees work eight 9-hour days and one 8-hour day and have one day off per pay period) to better align staffing with workload demands and improve access and productivity. Leaders acknowledged the new schedule's impact on employees and agreed to review productivity and access metrics annually to ensure the new hours continue to meet the needs of both veterans and employees. Leaders said the annual review was to occur after the OIG site visit in April 2026.

Additionally, executive leaders discussed the effect of the VHA Human Capital Management memorandum, *Position and Organizational Chart Management*, which required leaders to align positions with the budget and remove excess vacant positions.[17] At the time the memorandum

[16] 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.

[17] Acting Chief Operating Officer (10C), Human Capital Management (106), "Position and Organizational Chart Management (VIEWS 13223853)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 20, 2025.

was issued in November 2025, the facility had nearly 400 part-time employees. Leaders reviewed all filled, vacant, and part-time positions and directed service chiefs to identify part-time positions that could be removed. They retained filled positions, eliminated vacant ones, and planned to reach the position limit through normal attrition. Leaders said they held meetings with service chiefs and conducted employee town halls to communicate these changes.

Employee Experiences

More than half of the respondents to the OIG questionnaire disagreed or strongly disagreed that the facility's culture was moving in the right direction, and over 40 percent did not feel comfortable suggesting actions to improve their work environment (see figure 2).

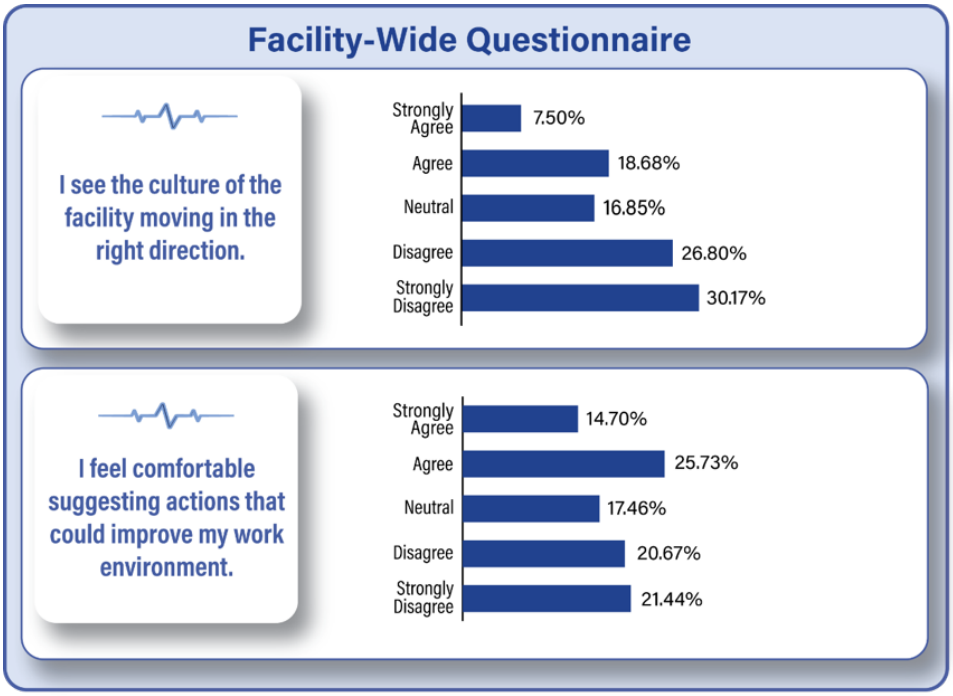


Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Responses also showed that employees stay at the facility because of the VA mission and pay and benefits (see figure 3). However, half of respondents identified poor executive leadership as a reason for leaving the facility.

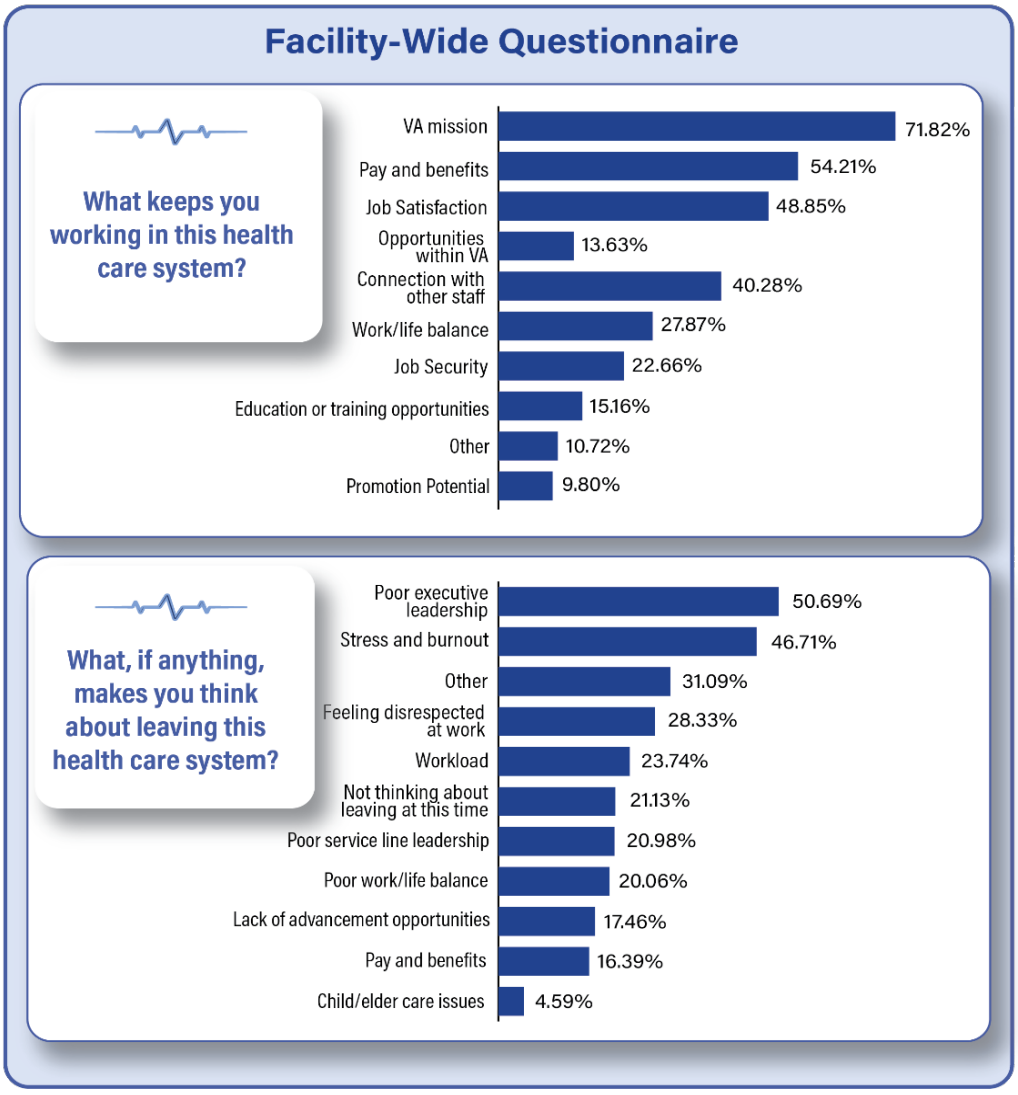


Figure 3. *Employees' indications of what keeps them working at the facility.*
Source: OIG analysis of selected questionnaire responses.

Although several employees said they feel executive leaders are supportive and communicate well with them, the OIG team received multiple requests from providers asking to meet so they could express concerns about the executive leadership team. During these interviews, common themes emerged, including lack of psychological safety (a shared belief that it is safe to take

risks within an organization), fear of retaliation, and poor communication.[18] The interviews highlighted how leaders are not meeting the High Reliability Organization principle for a culture of safety that is centered on trust and open communication, as expressed in the *Veterans Health Administration High Reliability Organization (HRO) Reference Guide*, for these providers.[19]

Leaders stated they hired an organizational health psychologist approximately two years previously to help improve facility culture through methods that included forming employee focus groups, assessing psychological safety, conducting rounds (visiting employees within their work units), and reviewing data to help develop action plans to address employee concerns. Leaders also said they strive to communicate clearly and transparently through monthly town halls, which are recorded for those unable to attend, and during rounds focused on patient safety. They also hold facility-wide tiered huddles (brief meetings that include leaders and frontline employees), distribute weekly videos from the Director, and provide updates during visits to community-based outpatient clinics.[20] Additionally, the OIG team reviewed documents that showed facility leaders invested in employee experiences through initiatives such as *VA Voices*, which connects employees to the VA mission, and the Whole Health and Wellness program, which helps employees develop individualized health plans for well-being.

Although executive leaders stated they were aware of the concerns and discussed the above facility-wide actions to improve communication, some providers told the OIG they still lack trust in the executive leaders and do not feel psychologically safe. The OIG inspection team referred this finding to another directorate within the VA OIG for further evaluation and made a recommendation to the Veterans Integrated Service Network.[21]

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[18] 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.

[19] VA, *VHA High Reliability Organization (HRO)*, *Reference Guide*, September 2024.

[20] Naseema B. Merchant, et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000.

[21] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, 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.

Recommendation 1

The Veterans Integrated Service Network Director takes action so that executive leaders establish trust and a culture of safety, in accordance with the *Veterans Health Administration High Reliability Organization (HRO) Reference Guide*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

Veterans Integrated Service Network leadership assisted with resolving 4 years of rotating temporary leadership in the VA Salt Lake City Health Care System Chief of Staff position, hiring the current Chief of Staff in February 2026. Moving forward, VISN 4 will continue to address and support facility leadership and providers by reviewing the actions taken by the facility over the ensuing months and facilitate a focused assessment of provider psychological safety to determine barriers and opportunities for improvement. Based upon findings, the VISN will assist the facility leadership to implement any necessary adjustments to reestablish trust and a culture of safety in accordance with High Reliability Organization principles.

Veteran Experiences

The OIG team found the facility's VSignals scores showing veterans' level of trust for FY 2025 were 94 percent, which was the same as VHA's national average. Patient advocate respondents to an OIG questionnaire reported that veterans most often complained about problems reaching employees by telephone. In an interview, the executive leaders acknowledged the issue. Leaders stated they have made changes to the phone system but added that many veterans do not like having to call into a call center. Telephone access directly affects veterans' ability to obtain timely care and shapes their overall experience.

To respond to veteran concerns more broadly, executive leaders said they receive weekly reports from patient advocates, meet regularly with veteran organizations, hold monthly meetings with veteran advisory boards, and conduct quarterly virtual veteran town halls that averaged 6,000 participants. They also reported speaking with veterans throughout the facility, who they said feel comfortable sharing their concerns and information with them.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[22] 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.[23]

General Inspection

The George E. Wahlen VA Medical Center consists of multiple buildings spread across 81 acres. The OIG team observed directional signs at the property entrance and throughout the site. The parking lots and garage had ample parking, including accessible spaces for those with disabilities, along with security cameras and emergency call boxes.

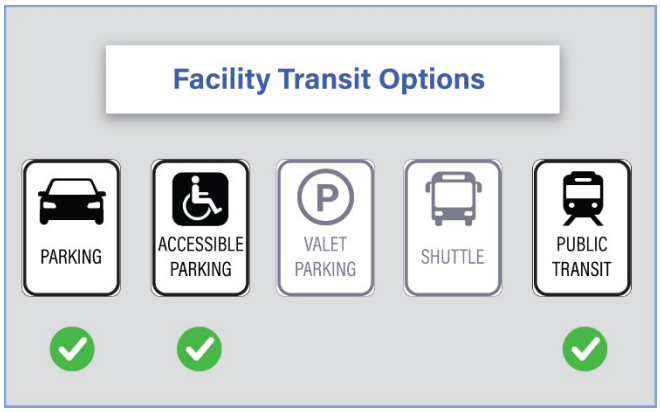


Figure 4. *Transit options for arriving at the facility. Source: Facility liaison responses to a questionnaire and a document request, facility maps, a parking summary spreadsheet, and OIG team observations.*

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

[23] 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 5. *Accessibility tools available to veterans with impairments.*
Source: Facility maps, policies and procedures, facility liaison questionnaire responses, and OIG team observations.

At the main entrance, doors opened into a clean, well-lit lobby with a large seating area. Staff and volunteers at the information desk provided directions and escorted veterans to appointments. The inspection team noted directories posted in hallways, near elevators, and on walls throughout the facility.

During the April 2026 inspection, the OIG team assessed patient care areas and interviewed staff. The team found the facility to be clean and well lit. Personal protective equipment was readily available, contaminated medical waste was properly stored with restricted access, medications and medical supplies were secured, and there were no expired items.

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's Medical Center Policy 11.104, *Communicating Test Results*, met the requirements of VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[24] The facility policy included processes to communicate test results to providers and patients and assign a surrogate (designee) when a provider is unavailable or has left the facility, and outlines how to convey results outside regular clinic hours. During an interview, leaders said they had previously identified gaps in their service-level workflows related to roles, responsibilities, and escalation processes in communicating test results and had since updated

[24] George E. Wahlen VA Medical Center, MCP [medical center policy] 11.104, *Communicating Test Results*, April 17, 2026; VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

them. The OIG team found that the updates clarified roles and responsibilities, streamlined after-hours communication processes, and provided guidance for transitions between care settings. Leaders reported that staff received education on the revisions.

During an interview, the informatics officer said the facility has processes to inform providers about test results, including those from community providers. Providers receive timely notification of test results through the view alert system (which sends electronic messages that prompt action).[25] The informatics officer reviews view alert data weekly with service chiefs and collaborates with providers who have unaddressed alerts. According to the informatics officer, these processes have reduced the number of unaddressed view alerts.

VHA Directive 1088(1) also requires facilities to monitor test result communications to providers and patients through the external peer review program, which can help leaders assess compliance with test result communication requirements and ensure staff take corrective actions when needed. The external peer review program coordinators relayed that they monitor abnormal test results that require follow-up and discuss these results and any emerging trends with facility leaders. Overall, the OIG team found that facility leaders had consistent processes to monitor and address deficiencies in these communications, as demonstrated by an increase in external peer review compliance scores from 92 percent in the fourth quarter of FY 2025 to 100 percent in the first quarter of FY 2026.

The acting chief of radiology stated that the facility uses the National Teleradiology Program to interpret after-hour radiology diagnostic exams, but facility leaders reported delays in receiving results due to vacant positions in the program.[26] Timely and reliable communication of test results is essential to patient safety, diagnostic accuracy, and continuity of care; delays in interpretation or gaps in staffing can increase risk to patients. Leaders provided a contingency plan for delays but stated that two radiologists' resignations contributed to coverage shortfalls. They are trying to recruit radiologists but face competition from community hospitals that offer higher salaries. Leaders said they are also working to secure contract radiologists to interpret both urgent and routine results as needed.

[25] VA Office of Information & Technology, *Computerized Patient Record System (CPRS) User Guide: GUI Version*, October 2024.

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

Action Plans and Process Improvements

The OIG team found all recommendations from the previous OIG healthcare inspection had been closed.[27] According to facility documents, previous VHA and Joint Commission oversight reviews identified several deficiencies that required corrective actions to meet safety, compliance, and operational standards.[28] The team confirmed staff had corrected the previously identified deficiencies.

Quality management staff stated that employees use multiple methods to identify improvement opportunities; however, they reported that some employees were reluctant to report patient safety events because of a lack of feedback from leaders. To understand employees' perspectives, the systems redesign supervisor conducted focus groups, and patient safety managers distributed surveys. Results showed that employees wanted leaders to communicate the outcomes and details of patient safety event reports. However, leaders cannot provide outcomes and details that fall under quality assurance information because it is protected under 38 U.S.C. § 5705.[29] In response to the survey results, quality management staff stated they implemented a patient safety newsletter, provided monthly patient safety information and lessons learned in forums, and added biannual training to improve safety reporting communication. Patient safety managers relayed they also developed a software application to provide general follow up information to employees who identified concerns and said they received positive feedback.

Community care leaders reported they monitor patient safety events, identify trends, and implement action plans as needed. Leaders identified delays in community providers communicating lung radiology and abnormal mammogram results to facility providers. The systems redesign supervisor stated that in March 2026, staff designed a project to improve the communication of lung radiology results from community to facility providers, with a projected completion date for fall 2026. The women's health breast care coordinator also reported several improvements, including daily monitoring of patient records, implementing a communication workflow plan, and obtaining access to community provider medical record portals. Timely communication of abnormal test results is critical to preventing missed or delayed diagnoses, maintaining patient trust, and ensuring veterans receive safe, coordinated care across both facility and community settings.

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[27] VA OIG, *Comprehensive Healthcare Inspection of the VA Salt Lake City Health Care System in Utah*, Report No. 23-00013-128, August 10, 2024.

[28] Previous oversight reports included Veterans Integrated Service Network 19, *Annual Workplace Evaluation, Salt Lake City VA HCS [Health Care System] Survey*, February 2025, and The Joint Commission, *Final Accreditation Report George E. Wahlen VA Salt Lake City Health Care System*, August 2025.

[29] Quality assurance is any activity carried out as part of a systemic healthcare review for the purpose of improving medical care. VHA quality management documents that meet the requirements in 38 U.S.C. § 5705 are confidential and privileged. VHA Directive 1320, *Quality Management and Patient Safety Activities That Can Generate Confidential Records and Documents*, July 10, 2020.



VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[30] 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 OIG team found that gaps in the primary care workforce and high numbers of referrals increased workload demands and delayed patient access. From facility data and interviews, the OIG team learned there were approximately 79 primary care teams, many with multiple staffing vacancies at the time of the April 2026 inspection. As a result, staff reported the St. George, South Ogden, and Idaho Falls community-based outpatient clinics did not accept new patients, so they referred these veterans to community care. For those clinics accepting new patients, the average wait time for a new patient appointment was 22 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 longer than 20 days.[31]

In addition to vacancies, staff explained that managing the administrative workload, such as coordinating care and referrals for community care, appointment tracking, and medication refills, reduced available time for direct patient care, added strain to staff, and increased the risk of missed or delayed follow-up care. Primary care leaders reported they used several strategies to fill some of the vacant positions, including recruitment and relocation incentives and salary increases. They also used temporary staff coverage to help manage the workload. Leaders said several new primary care staff members are in the hiring process. Additionally, they described multiple process improvements to strengthen communication and reduce wait times. These included staff reviews of appointments to offer veterans earlier times when available, pre-appointment surveys to streamline visits, and adjustments to nurses' workloads.

Community Care Staffing and Access to Care

The OIG team found that the community care program experienced an increase in referral demands, gaps between authorized staff positions and operational needs, and workflow inefficiencies. Facility data showed an increase in referral volume from a monthly average of about 5,700 in FY 2025 to 6,500 from October 1, 2025, through April 15, 2026. In an interview,

[30] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.
[31] 38 C.F.R. § 17.4040 (2025).

community care leaders reported they are on target for a 10 percent increase in referrals from FY 2025 to FY 2026, which they attribute to fewer specialty care services offered at the facility and veterans being more aware of community care options.

According to leaders, despite the increased referrals, community care staffing has not increased to meet demand. At the time of the inspection in April 2026, 54 of 61 community care administrative positions and 34 of 37 nursing positions were filled, and leaders were hiring for the remaining vacancies. Leaders reported the program needed about 80 administrative staff to address the backlog of unscheduled referrals, and staff reported they needed 5 additional nurses to manage the workload. To address the staffing needs, leaders reported they were working to obtain a contract for 35 additional staff members.

Community care leaders stated the average time to schedule an appointment with a community provider was 66 days in July 2025, while VHA's *Consult Timeliness Standard Operating Procedure* requirement is within 7 days.[32] Leaders began addressing the delays and, at the time of the inspection in April 2026, had decreased the average time to schedule appointments to 38 days. Actions taken by leaders included using auto-send letters, which eliminated the need for staff to hand-stuff envelopes, and allowed staff to focus on processing referrals. Leaders improved the telephone call abandonment rate, which hindered appointment scheduling, from 48 percent to approximately 15 percent by increasing the number of staff answering calls and implementing an automated system that dials outgoing calls, then transfers the calls to a live person. However, VA Health Connect sets a telephone call abandonment target rate of less than 5 percent.[33] Although community care has not reached the scheduling requirement of 7 days or the telephone abandonment target of less than 5 percent, the OIG found the facility has robust action plans. The plans include monitoring data daily, holding staff accountable for completing work, and ensuring they have the tools and resources needed to be successful. Therefore, the OIG did not make a recommendation.

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

[33] VA Health Connect, *Data Definitions for the VA Health Connect Dashboard*, April 9, 2025.



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 VA or community-based residential programs for specialized treatment.[34]

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).[35] 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)."[36]

Performance and Improvement Highlights

- According to a program leader, the facility's HCHV program does not have any contracted beds, so the facility was exempt from the permanent housing (HCHV1) and negative exit (HCHV2) measures. Due to the lack of contracted beds, program employees said they rely on community shelters for housing and local funding from

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

[35] 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.

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

community partners to temporarily house veterans in motels. They also connect veterans with other housing assistance programs as needed.

- The homeless program director reported that the HCHV program has a supervisor, four dedicated social workers, and three additional staff who incorporate outreach into their positions to cover the large geographical area. Program employees shared that they lost two positions in FY 2024, which resulted in challenges in conducting rural outreach and keeping up with referrals. At the time of the inspection in April 2026, program leaders stated they were working to provide evidence and justification to restore the two positions to executive leaders.
- The program director identified the service area, which is approximately 125,000 square miles across three states, as a barrier to conducting outreach. The program director noted that each state has different homeless operations that employees must be knowledgeable about, which creates challenges.
- Program employees provided a calendar of program events and told the OIG team they hold multiple meetings with local officials, host resource fairs, and provide education about VHA programs.
- Program employees also highlighted their strong relationships with community partners and homeless coalitions. These partners help identify veterans and refer them to the program. Employees said they attend a weekly community meeting where they coordinate care with community providers.
- Additionally, the facility has a homeless primary care team and a mobile medical unit that support veterans' medical and mental health needs, both at the facility and across the service area, including in tribal communities.

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."[37] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[38]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[39]

Performance and Improvement Highlights

- The facility did not meet the voucher use (HMLS3) target for FY 2025.[40] However, program data showed they were close to meeting the FY 2026 target as of April 2026.[41] Despite this achievement, program employees told the OIG team that position removals and vacancies limited their ability to use all available vouchers and prevented them from acquiring more. In addition, employees reported difficulties finding safe and permanent housing for veterans with complex needs.
- The facility program also did not meet the FY 2025 employment (VASH3) target.[42] Program employees noted that many veterans have disabilities and mental health needs or are of advanced age, which limits their employability despite available jobs. Facility documents showed that the employment specialist began an employment clinic in March 2026 to help veterans aged 55 and over and those with legal issues find jobs.
- A program lead reported that the program has an entry team and a stabilization team. The lead described the entry team as "the front door," providing case management while veterans move through the housing application process. Once applications are approved, the stabilization team takes over. Each team includes multiple case managers, a nurse, and a supervisor. The OIG inspectors reviewed a document showing each team had one vacancy at the time of the on-site visit in April 2026.
- Additionally, program employees reported challenges with a local housing agency's program that provides housing for medically fragile and aging veterans. Employees described issues with rent accounting, environmental health responses (pest infestations), and service coordination. They noted that a pest infestation halted admissions in October 2025. Program employees and facility leaders are working with housing agency leaders and a third party to resolve the problems.

[39] 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.*

[40] At the end of FY 2025, the facility program used 77.32 percent of its allotted vouchers.

[41] As of April 2026, the facility program had used 89 percent of its allotted vouchers.

[42] The facility's program was at 39.50 percent employment for veterans.

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.[43] 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).[44]

Performance and Improvement Highlights

- The facility did not meet the enrollment (VJP1) target for FY 2025, but the program has shown steady improvement in FY 2026. Facility program staff attributed missing the goal to vacant positions that limited the number of referrals they could process. After hiring two employees in October 2025, bringing the team to five employees, the program lead said the facility should meet the target by the end of the fiscal year.
- Staff described working with multiple veteran treatment courts and recovery mental health courts—which supervise veterans through a program that provides monitored treatment and other services—across 27 counties and two states. Staff also described partnerships with several community agencies, including law enforcement, prison and jail staff, judges and legal clinics, and facility providers and clinicians.
- Staff explained referrals come from multiple sources, such as facility providers, families, and community members, as well as self-referrals from veterans.

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

[44] 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.*

Conclusion

To assist leaders in evaluating the quality of care at the VA Salt Lake City Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation to the Veterans Integrated Service Network Director to improve trust and psychological safety. 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.[45] 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 April 20 through 23, 2026, and followed up with facility staff in August 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.[46] 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.*[47]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[48] 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.

[45] The accreditation reports covered the time frame of October 1, 2022, through September 30, 2025—the most recent available at the time of the inspection.

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

[47] 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.

[48] 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 authorized by the Inspector General Act of 1978.[49] 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.

[49] 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: October 21, 2026

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

Subj: Healthcare Facility Inspection of the VA Salt Lake City Healthcare System in Utah

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report for the Healthcare Facility Inspection of the VA Salt Lake City Healthcare System in Utah.
2. Based upon a thorough review of the report by VISN 4 leadership, I concur with the findings, recommendations and submitted action plans of VISN 4: HSA 4.2. As we remain committed to ensuring our Veterans receive exceptional care, VISN 4 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.
3. If you have any questions or require further information, please contact the VISN 4 Quality Management Officer.

(Original signed by:)

Fernando O. Rivera, FACHE
Network Director
VA Heart Of America Health Network

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 15, 2026

From: Director, VA Salt Lake City Healthcare System (660)

Subj: Healthcare Facility Inspection of the VA Salt Lake City Healthcare System in Utah

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

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the VA Salt Lake City Healthcare System in Utah.
2. I have reviewed the report and concur in principle with the recommendation. We recognize the results of the staff survey; however, it is unclear whether respondents had the same group in mind when identifying executive leadership, particularly during a period of significant change within VHA. In addition, the executive leadership team was aware that some providers had expressed concerns related to an employee separation, and the executive leadership team was transparent with the OIG regarding this issue during the opening briefing. The facility reviewed the entire report; as the recommendation is directed to the VISN Director, the facility did not develop a separate action plan.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the Chief of Quality, Safety, and Value.

(Original signed by:)

Angela D. Williams, Pharm.D., M.S., VHA-CM
Director, VA Salt Lake City Health Care System

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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.