US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Texas Valley Coastal Bend Healthcare System in Harlingen

Healthcare Facility Inspection	25-00189-199	August 21, 2025

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA Texas Valley Coastal Bend Healthcare System (facility) from December 10 through 12, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders identified VHA's strategic hiring efforts to reduce total staff numbers as a system shock.[2] To mitigate its effects, leaders focused on communication with staff through town halls and hiring to meet veterans' needs. Related scores from the facility's VA All Employee Survey improved between fiscal years (FYs) 2022 and 2024 and were higher than VHA averages.[3]

Additionally, executive leaders said the patient advocate team effectively addressed veterans' concerns, but they also acknowledged challenges caused by delayed prosthetics deliveries and a

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

[2] "The FY [20]25 budget requires that VHA reduce cumulative staff–without sacrificing the world-class care that we are providing Veterans. To execute that plan, we must make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach" memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO Program Office Leadership, May 31, 2024.

[3] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

backlog of prosthetic orders.[4] The OIG requests Veterans Integrated Service Network (VISN) leaders help facility leaders identify the reasons for delays in prosthetics deliveries and take necessary actions.[5]

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The OIG inspected the Harlingen VA Clinic, which included outpatient primary care and specialty clinics, but no inpatient units. The clinic was accessible by public transportation, but the nearby bus stop did not have a sign. The OIG suggests facility leaders coordinate with local transit officials to evaluate opportunities to better identify the public bus stop at the clinic.

Due to its small size, the OIG found navigation in the clinic easy despite a lack of printed or electronic maps. Additionally, each floor had an information desk with staff available to assist with navigation. Because the clinic was leased property, staff sometimes experienced difficulties when requesting repairs or maintenance from the owner. For example, the Chief of Facilities reported asking the property owner to repair faded pavement markings in the parking garage, but the owner declined to repair them prior to scheduled maintenance. Despite this issue, the OIG found the clinic to be generally clean and well maintained.

The OIG identified concerns with toxic exposure screenings. Although facility leaders regularly reviewed veterans' screening status with chief medical officers, at the time of the site visit, there were 1,326 incomplete screenings (screenings staff initiated but an authorized provider did not complete) that were more than 30 days old, and the OIG made a related recommendation.[6]

Finally, the OIG observed private patient information left unattended at a station for drawing blood samples, which did not align with the facility's policy on securing sensitive information.[7]

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[4] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/. A prosthetic device is "any device that supports or replaces a body part or function," "Rehabilitation and Prosthetic Services," Department of Veterans Affairs, accessed March 14, 2025, https://www.rehab.va.gov/psas/index.asp.

[5] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[6] Department of Veterans Affairs, "Phase Two, The Toxic Exposure Screening Process in The CPRS [Computerized Patient Record System] Clinical Reminder," updated April 2023.

[7] VA Texas Valley Coastal Bend HCS [Healthcare System] MCP [medical center policy] 00-24-39, *Securing Sensitive Information*, May 24, 2024.

The OIG did not make a recommendation because a facility leader plans to address the problem directly with laboratory managers.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility's test result communication policies generally aligned with the VHA directive.[8] However, service-level workflows must explain which test results are considered actionable and nonactionable and include time frames to notify specific high-risk populations.[9] The OIG recommends leaders align service-level workflows with the VHA directive.

During OIG interviews, several service leaders identified an additional problem involving delays in facility providers receiving test results from community providers, and a primary care leader shared it could take weeks or months to receive the results.[10] The Director described expanding services at the facility to reduce reliance on community care and therefore delays with getting test results from community providers. Facility leaders outlined several initiatives taken to decrease the use of community care, such as adding additional specialty services and clinics and partnering with the VISN 17 clinical resource hubs and VA telemedicine, which provide health care to patients remotely.[11]

The OIG inspection team referred a concern to OIG's hotline team that involved a community provider's delayed communication of test results to a facility provider. The OIG also requests that VISN leaders evaluate the timeliness of test result communication between community and facility providers, identify any vulnerabilities, and take action, as needed.

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[8] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024; VA Texas Valley Coastal Bend HCS MCP 11-24-100(1), *Communicating Test Results to Providers and Patients*, October 21, 2024, amended November 13, 2024; VA Texas Valley Coastal Bend HCS Policy Memorandum 113-21-08, *Reporting Abnormal Laboratory Test Results*, July 12, 2021; VA Texas Valley Coastal Bend HCS SOP [standard operating procedure] 114-24-15, *Ordering, Scheduling, & Reporting Radiology Studies*, October 3, 2024. The OIG reviewed the facility's applicable medical center policies and standard operating procedures.

[9] "A service-level workflow is a written document that describes the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1).

[10] Community care is when "VA provides health care for Veterans from providers" in a patient's "local community outside of VA." "Community Care, Veteran Care Overview," Department of Veterans Affairs, accessed December 17, 2024, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

[11] Clinical resource hubs are "VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Patient Care Services, Clinical Resource Hubs," Department of Veterans Affairs, accessed December 26, 2024, https://www.patientcare.va.gov/primarycare/CRH.asp.

Further, the OIG reviewed the facility's practices for continuous process improvement. The Systems Redesign Coordinator explained how staff host brainstorming meetings to develop project improvement ideas, then use a VHA quality improvement tracking tool to monitor the projects.

The OIG also reviewed some Peer Review Committee meeting minutes and found the Chief of Staff was not present for 6 of 13 meetings.[12] Although a designee attended the other meetings, VHA requires the Chief of Staff to only be absent occasionally.[13] The OIG determined the Chief of Staff's absences to be more than occasional and recommends the Director ensures the Chief of Staff attends the meetings.

Primary Care

The OIG determined whether the primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected primary care delivery structure and new patient appointment wait times.[14] The facility provides primary care services at their multiple outpatient clinics and two mobile medical units.[15] The mobile units serve veterans located in the most rural parts of the service area.

The Associate Chief of Staff of Primary Care reported that it had been difficult to recruit primary care providers due to a national shortage within VA. However, leaders hired 20 primary care providers in FY 2024. The leader described using a variety of recruitment and retention tools, including employing a physician recruiter and hiring residents after they complete their training programs at the facility. In response to nursing turnover, leaders used financial incentives to encourage nurses to stay in primary care, and the Associate Director for Patient Care Services said staffing had stabilized.

Moreover, primary care staff said they feel supported by leaders and their workload is manageable. Primary care staff and leaders attributed the manageable workload to good communication among staff when they need additional assistance. Each primary care team is paired with another team to cover as needed, which also allows team members to have dedicated administrative time (work hours to address nonclinical duties). Primary care staff also stated the

[12] Peer review for quality management is a process in which a provider examines another provider's care to determine areas for individual improvement, system-wide improvement, or both. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

[13] The Chief of Staff must chair the peer review committee, and "in the occasional absence of the Chief of Staff, a designee may be appointed." VHA Directive 1190(1).

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

[15] The facility's mobile medical units are large vans or trucks that resemble recreational vehicles that move from one location to another where patients can meet with medical providers and other staff who provide services including primary care, women's health, laboratory, and telehealth.

PACT Act did not cause a noticeable increase in workload, despite a 4.7 percent increase in veteran enrollment attributed to the act's implementation.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans program did not meet the target for veterans receiving intake assessments for FYs 2022 through 2024. The Health Care for Homeless Veterans Program Supervisor stated the COVID-19 pandemic was a barrier to enrollment in FYs 2022 and 2023, and many community partners had shut down and were slow to reopen. Overall, the Housing and Urban Development–Veterans Affairs Supportive Housing and Veterans Justice Program met performance measures for using assigned housing vouchers and employing and enrolling veterans in FYs 2023 and 2024.

What the OIG Recommended

The OIG made three recommendations.

1. Facility leaders identify barriers to providers completing toxic exposure screenings and implement actions to ensure providers complete screenings within 30 days of initiation.
2. Facility leaders ensure each service has a service-level workflow for test result communication that is consistent with VHA requirements.
3. The Director ensures the Chief of Staff attends Peer Review Committee meetings.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the inspection findings and recommendations 1 and 2, concurred in principle with recommendation 3, and provided acceptable action plans (see appendixes C and D). Based on the information provided, the OIG considers recommendations 2 and 3 closed. The OIG will follow up on the planned actions for the remaining open recommendation until they are completed.

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

Abbreviations

ADPCS	Associate Director for Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Texas Valley Coastal Bend Healthcare System
Harlingen, Texas
Level 2-Medium Complexity
Cameron County
Hospital Referral Region: Harlingen

Description of Community

POPULATION

Female **672,222**	Male **648,319**
Veteran Female **3,404**	Veteran Male **33,885**

Homeless - State **24,432**
Homeless Veteran - State **1,711**

MEDIAN INCOME

$44,440

EDUCATION

69% Completed High School
49% Some College

VIOLENT CRIME

Reported Offenses per 100,000 | **319**

SUBSTANCE USE

26.2% Driving Deaths Involving Alcohol
17.1% Excessive Drinking
74 Drug Overdose Deaths

UNEMPLOYMENT RATE

9% Unemployed Rate 16+
6% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

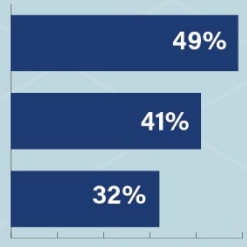
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**16 Minutes, 13 Miles**
Specialty Care	**26 Minutes, 25 Miles**
Tertiary Care	**241 Minutes, 274 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **20,009**



Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

16,407

N/A VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

N/A

30-DAY READMISSION RATE

N/A

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
18	37

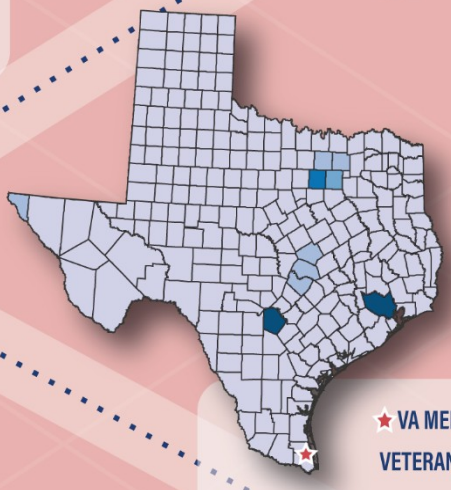
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	49K
Unique Patients VA Care	45K
Unique Patients Non-VA Care	34K

COMMUNITY CARE COSTS

Unique Patient $12,826	Outpatient Visit $329
Line Item $499	Bed Day of Care $206



STAFF RETENTION

Onboard Employees Stay <1 Yr	10.21%
Facility Total Loss Rate	9.94%
Facility Retire Rate	1.43%
Facility Quit Rate	7.97%
Facility Termination Rate	0.54%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.00% 2.29% 4.58% 6.86% 9.14% 11.42%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

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Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection cyclical review program to help accomplish its mission. Healthcare Facility Inspection teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

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

Healthcare Facility Inspection reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

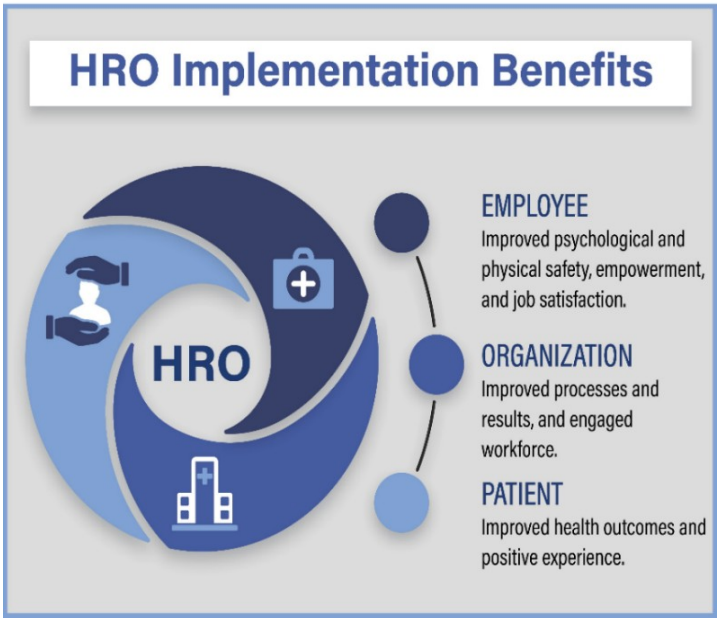

Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

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

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

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

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Undersecretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Content Domains

Figure 3. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The VA Texas Valley Coastal Bend Healthcare System (facility) is in south Texas.[13] The Associate Director stated the facility opened in 2011 and the Associate Director for Patient Care Services (ADPCS) reported the facility offered outpatient services only. The Director explained that at the time of the OIG inspection, all the facility's clinics, except the Corpus Christi Specialty Clinic, were leased.

Facility executive leaders consisted of the Director, Chief of Staff, Deputy Chief of Staff, ADPCS, Deputy ADPCS, and Associate Director. The newest member of the leadership team, the Associate Director, was assigned in August 2023, and the most tenured, the Director, in January 2019. The Associate Director reported the facility's budget as approximately $746 million in fiscal year (FY) 2024.

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] The VA Texas Valley Coastal Bend Healthcare System includes the Harlingen VA Clinic and community-based outpatient clinics in Brownsville, Corpus Christi, Harlingen, Laredo, and McAllen. "VA Texas Valley Health Care, Locations," Department of Veterans Affairs, accessed June 18, 2025, https://www.va.gov/texas-valley-health-care/.

[14] 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.

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

[16] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

The Director reported a system shock that occurred at the start of FY 2024, when Veterans Integrated Service Network (VISN) 17 leaders notified facility executive leaders of VHA's strategic hiring effort to reduce the total number of staff in FY 2025.[19] The Director stated this led some staff to mistakenly believe the facility was in a budget deficit. To reduce confusion, the Director hosted a town hall to explain the hiring strategy adjustments. The Director also said the facility has a goal to offer veterans more specialty services at the facility, such as cardiology, to reduce reliance on community care providers.[20] The Director added that it was a challenge to hire staff to provide more services while trying to reduce the total number of staff. However, leaders continued to hire staff necessary to meet veterans' needs.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright

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

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

[19] "The FY [20]25 budget requires that VHA reduce cumulative staff–without sacrificing the world-class care that we are providing Veterans. To execute that plan, we must make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), and VHACO Program Office Leadership, May 31, 2024. VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[20] Cardiology is the study of the heart and disorders of the heart. *Merriam-Webster*, "Cardiology," accessed March 14, 2025, https://www.merriam-webster.com/dictionary/cardiology.

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

culture.[22] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[23] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]

Figure 4. *Leader communication with staff.*
Source: OIG analysis of interviews with facility leaders.

The Chief of Staff reported using different approaches to facilitate communication between executive leaders and staff. The chief told the OIG that some employees' primary language is Spanish and to effectively communicate, they share information in both Spanish and English. Executive leaders also explained that when issues arise in various departments, they meet with employees at their work location to openly talk about their concerns. The OIG's review of VA All Employee Survey responses related to leader communication, information sharing, and transparency revealed scores improved from FYs 2022 through 2024, beating VHA averages each year.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

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[22] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[23] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

[24] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

[25] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

[26] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

The OIG found VA survey scores related to no fear of reprisal, best places to work, and workgroup psychological safety were higher than VHA averages for FYs 2022 through 2024. The Chief of Staff attributed these scores to executive leaders' focus on stability, consistency, and accountability for all staff. Additionally, the Chief of Staff said the Director had hired a Chief Wellness Officer two years previously, the first VISN 17 facility to do so. The Chief Wellness Officer's duties included reviewing survey scores, working with employees to address areas for improvement, and implementing strategies to improve overall employee well-being. For example, the chief identified areas with employee burnout and worked with staff in those areas.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[27] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[28] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

The Director said the patient advocate team briefs leaders on veterans' concerns and effectively addresses them. Patient advocates stated facility leaders are responsive to veterans' concerns, such as requests to change providers. The Director also emphasized the importance of maintaining positive relations with VSOs by resolving issues as they arise.

However, primary care staff described a problem with timely delivery of prosthetics equipment to veterans.[29] Staff shared one example of a veteran with a sprained thumb who did not receive a splint for six months.[30] VHA requires facilities to ensure timely delivery of prosthetics to veterans.[31] The Associate Director explained there was a backlog due to delays in receiving prosthetic equipment from community vendors. To improve the situation, the Associate Director said staff worked extra hours to address the backlog, and the Chief of Prosthetics provided leaders with daily progress reports on the number of open orders. The OIG requests that VISN leaders help facility leaders identify reasons for delayed prosthetics deliveries and take necessary actions to resolve the problems.

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

[28] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

[29] A prosthetic device is "any device that supports or replaces a body part or function." "Rehabilitation and Prosthetic Services," Department of Veterans Affairs, accessed March 14, 2025, https://www.rehab.va.gov/psas.

[30] A splint is "material or a device used to protect and immobilize a body part (such as a broken arm)." *Merriam-Webster*, "Splint," accessed June 9, 2025, https://www.merriam-webster.com/splint.

[31] VHA Directive 1173, *Prosthetic and Sensory Aids Service*, March 27, 2023.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[32] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 5. *Facility photo.*
Source: "VA Texas Valley Coastal Bend Health Care System," Department of Veterans Affairs, accessed May 28, 2025, https://vaww.va.gov/directory/facility. (This web page is not publicly accessible.)

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

[32] VHA Directive 1608(1).

[33] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[34] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

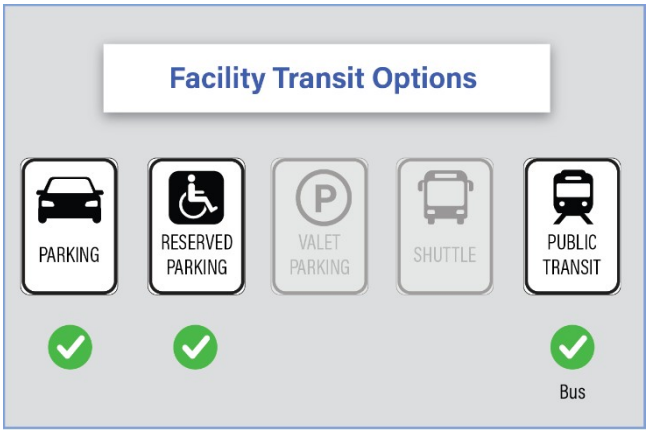

Figure 6. *Transit options for arriving at the facility.*
Source: Facility staff and OIG observations.

The OIG used a commercial navigation application to travel to the facility and found the instructions easy to follow. The Harlingen VA Clinic consisted of a single, three-story building with an adjacent parking garage. The garage had sufficient general parking and spaces accessible to those with disabilities. The clinic was also reachable by public transport, but the OIG noted the bus stop, which was near the building, did not have a sign. The OIG suggests facility leaders coordinate with local transit officials to evaluate opportunities to better identify the public bus stop at the clinic.

Main Entrance

Figure 7. *Adopt a Warrior display in the main lobby of the Harlingen VA Clinic, December 2024.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[35] The OIG found the main entrance spacious and well-lit, with available wheelchairs, masks in dispensers, and an information desk. However, greeters at the information desk reported there were no printed or electronic maps of the facility available. Despite the lack of maps, the OIG found the clinic easy to navigate because of its small size.

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

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[36] The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37]

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents, observations, and interviews.

The OIG observed features to help those with visual impairments navigate, including raised symbols (braille) on signs and auditory cues in elevators. There were additional information desks on each floor with staff to assist veterans as needed. Information desk staff reported they communicate with individuals with hearing loss through writing. While the OIG did not observe closed captioning, common area televisions displayed educational content with printed text, along with images and videos.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[38]

The Chief of Quality Management reported the facility has two toxic exposure screening navigators. Despite being navigators as a collateral (additional) job duty, both stated they have

[36] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[37] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

[38] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

adequate time and resources to complete their responsibilities, which included acting as subject matter experts on toxic exposure screenings and coordinating screenings at the facility.[39]

The Deputy Associate Chief of Staff of Primary Care said they discuss incomplete screenings (screenings staff initiate but an authorized provider did not complete) with chief medical officers weekly. Additionally, the deputy stated an administrative officer emails a list of incomplete screenings to chief medical officers to identify which providers need to follow up with veterans to finish them. However, at the time of the inspection, the OIG reviewed toxic exposure screening data and found 1,326 incomplete screenings that were more than 30 days old. VHA expects providers to complete toxic exposure screenings within 30 days.[40] The OIG recommends facility leaders identify barriers to providers completing toxic exposure screenings and implement actions to ensure providers complete them within 30 days of initiation.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[41] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues. During this inspection, the OIG did not identify any repeat findings or unaddressed recommendations.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.[42]

The OIG inspected multiple outpatient primary and specialty care clinics at the Harlingen VA Clinic and found the environment to be generally clean and well maintained. However, because most of the facility's clinic buildings were leased space, staff reported maintenance challenges

[39] The VHA expects toxic exposure screening navigators to "act as subject matter expert (SME) for Toxic Exposure Screening and facilitate streamlined rollout, coordination, and optimization of the Toxic Exposure Screening implementation efforts at each VHA facility within assigned VISN's." VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*.

[40] Department of Veterans Affairs, "Phase Two, The Toxic Exposure Screening Process in the CPRS [Computerized Patient Record System] Clinical Reminder," updated April 2023.

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

[42] The facility offers outpatient services only and did not have inpatient or community living center beds.

due to coordinating repairs with various property owners under different lease agreements. For example, when the OIG noted the parking garage's top floor had faded pavement markings, the Chief of Facilities reported asking the property owner to repair them, but the owner declined to act prior to scheduled maintenance. Despite such barriers, the OIG observed no environment of care deficiency trends.

At a station for drawing patient blood samples, however, the OIG observed a list of patient names and Social Security numbers on top of a cabinet and unattended by a staff member. The OIG reviewed the facility policy on securing sensitive information, which stated unattended patient information left in plain sight is not permissible.[43] The laboratory supervisor explained staff could leave the information in plain sight because the area is behind a locked door, and laboratory staff escort patients and any non-laboratory staff when they are in the space. The OIG did not issue a recommendation because a facility leader reported plans to address this privacy concern with laboratory managers.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[44] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

[43] VA Texas Valley Coastal Bend HCS [Healthcare System] MCP [medical center policy] 00-24-39, *Securing Sensitive Information*, May 24, 2024.

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

[45] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

The OIG reviewed the facility's policies and a standard operating procedure related to test result communication and found they generally aligned with the VHA directive.[46] However, staff provided a service-level workflow to the OIG that did not define actionable and nonactionable results or reference other policies to explain which type required what action to communicate those results in a timely manner.[47] The workflow also did not include time frames for communicating the results for specific high-risk populations, as required.[48] The OIG recommends facility leaders ensure each service has a service-level workflow for test result communication that is consistent with VHA requirements.[49]

Despite the problems with the service-level workflow, the Associate Chief of Staff of Primary Care was able to explain the process and time frames providers use to communicate test results to patients. Similarly, the Deputy Chief of Staff described the communication process staff use in Pathology and Laboratory Services, including warm-handoff communication for critical and urgent test results.[50]

The Chief of Radiology explained that staff in the service use an internal tracking and audit process to ensure radiologists report clinical findings as required. The Chief of Quality Management stated the staff share the tracking results during monthly Quality Executive Board meetings, which executive leaders attend.

Several service leaders identified test result communication delays from community to facility providers as a barrier to safe patient care.[51] The Chief of Community Care reported community care staff request test results and records daily from community providers, but the Associate Chief of Staff of Primary Care said it still may take weeks or months to get them. To reduce

[46] VHA Directive 1088(1); VA Texas Valley Coastal Bend HCS MCP 11-24-100(1), *Communicating Test Results to Providers and Patients*, October 21, 2024, amended November 13, 2024; VA Texas Valley Coastal Bend HCS Policy Memorandum 113-21-08, *Reporting Abnormal Laboratory Test Results*, July 12, 2021; VA Texas Valley Coastal Bend HCS SOP [standard operating procedure] 114-24-15, *Ordering, Scheduling, & Reporting Radiology Studies*, October 3, 2024.

[47] "A service-level workflow is a written document that describes the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1).

[48] VHA requires service-level workflows to define "how (modality and timeline) the VA medical facility ordering provider or designee coordinates communication of life-changing test results" to patients with a high risk for suicide. VHA Directive 1088(1).

[49] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

[50] Synchronous communication is defined by VHA as "communication that occurs when parties involved are all present at the same time, such as in person, telephone or Clinical Video Telehealth conversations." Further, VHA notes that synchronous methods of communication are preferred for "certain types of test results and certain types of patients." VHA Directive 1088(1). Synchronous communication is also known as warm-handoff communication.

[51] Community care is when "VA provides health care for Veterans from providers" in a patient's "local community outside of VA." "Community Care, Veteran Care Overview," Department of Veterans Affairs, accessed December 17, 2024, https://www.va.gov/COMMUNITYCARE/programs/veterans/index.asp.

patients' reliance on community care and delays in getting test results from community providers, the Director described efforts to expand services provided at the facility. For example,

- leaders reported they hired more cardiologists and pulmonologists, and discussed plans to open an urgent care center at the McAllen VA Clinic by late December 2024;
- the Associate Chief of Primary Care said they added musculoskeletal clinics to primary care services in August 2024 to treat patients with joint pain or minor joint injuries; and
- the Chief of Staff stated the facility partnered with regional specialists via VISN 17 clinical resource hubs and with VA telemedicine specialists nationwide who provide healthcare services virtually to increase patients' access to specialty care.[52]

The OIG discussed a community provider's delayed communication of test results to a facility provider with staff, and referred the issue to OIG's hotline team for further review. The OIG requests VISN leaders evaluate the timeliness of test result communication between community and facility providers, identify any vulnerabilities, and take action as needed.

In addition, the OIG examined the overall status of the facility's Peer Review Committee. The OIG looked at FY 2024 Peer Review Committee meeting minutes and found the Chief of Staff did not attend 6 of 13 meetings. VHA requires the Chief of Staff to chair the peer review committee, be absent only occasionally, and appoint a designee when not present.[53] Although a designated chair was present during the chief's absences, the OIG determined these absences exceeded VHA's intent to allow the chief to occasionally appoint a designee.[54] The Chief of Staff explained the absences were due to conflicts with other meetings. The OIG recommends the Director ensures the Chief of Staff attends Peer Review Committee meetings.[55]

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are

[52] A pulmonologist is a doctor who specializes in lung conditions and the respiratory system. "Pulmonologist," Cleveland Clinic, accessed March 17, 2025, https://my.clevelandclinic.org/pulmonologist. Clinical resource hubs are "VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Patient Care Services, Clinical Resource Hubs," Department of Veterans Affairs, accessed December 26, 2024, https://www.patientcare.va.gov/CRH.asp.

[53] VHA Directive 1190(1).

[54] VHA Directive 1190(1).

[55] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

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

The facility did not have any open recommendations from prior OIG reports, and the Chief of Quality Management said there were no open recommendations from other oversight agencies related to test result communication.[57] When asked how they managed the status of open actions for recommendations, the Chief of Quality Management explained that staff track them through an electronic monitoring system and present them to the Quality Executive Board.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[58] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[59] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In an interview, the Systems Redesign Coordinator explained the facility's patient safety programs incorporate continuous learning processes, such as hosting monthly brainstorming meetings for staff to develop project improvement ideas and using a VHA quality improvement tracking tool to monitor the projects. Similarly, the Deputy Chief of Staff described continuous learning in the Pathology and Laboratory Services, where staff review close calls in a monthly quality improvement meeting, then use the information in system-wide studies, such as root cause analyses, to improve processes.[60] The Associate Chief of Staff of Primary Care explained how primary care supervisors give feedback to providers on the timeliness of test result communication and unresolved alerts in the electronic health record system using data from monthly reports generated by the Chief of Informatics.[61]

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

[57] VA OIG, *Comprehensive Healthcare Inspection of the VA Texas Valley Coastal Bend Health Care System in Harlingen*, Report No. 22-00042-91, March 30, 2023. The facility did not have any OIG Hotline reports in fiscal years 2023 or 2024.

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

[59] VHA Directive 1050.01(1).

[60] VHA defines a close call as "an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention." A root cause analysis is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

[61] Alerts are computerized "auditory or visual warnings to clinicians to prevent or act on unsafe situations." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

The OIG also asked service leaders about alert fatigue, which occurs when staff become desensitized to numerous notifications in the electronic health record system. The Chief of Staff highlighted efforts to reduce providers' administrative burden (including alert fatigue). The chief shared a facility policy that identifies the types of communication that require alerts, which is intended to minimize the number of alerts staff receive.[62] Additionally, the Associate Chief of Staff of Primary Care described an automated letter process used to notify patients of normal test results and indicated this helped reduce alert fatigue and administrative workload for providers.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[63] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[64] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[65] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The facility provides primary care services at multiple outpatient clinics in south Texas. The Associate Chief of Staff of Primary Care reported there are also two mobile medical units, based in McAllen and Corpus Christi, that are equipped to provide audiology (hearing- and balance-related services), women's health, primary care, telehealth, and laboratory services.[66] Primary

[62] VA Texas Valley Coastal Bend HCS (MCP 00-21-56), *Use of Additional Signer Function*, November 15, 2021.

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

[64] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

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

[66] "Audiology is the science of hearing, balance, and related disorders." "Learn About the CSD [Communication Sciences and Disorders] Professions: Audiology," American Speech-Language-Hearing Association, accessed June 24, 2025, https://www.asha.org/Students/Audiology/. The facility's mobile medical units are large vans or trucks that resemble recreational vehicles that move from one location to another where patients can meet with medical providers and other staff who provide various services.

care providers use the mobile units to care for patients in the most rural service areas who may be unable to travel long distances.

During the inspection, primary care leaders confirmed there were 45 primary care teams and identified the following vacant positions: three primary care providers, four licensed vocational nurses, and five medical support assistants.[67] The Associate Chief of Staff of Primary Care reported that recruiting had been difficult due to a national shortage of VA primary care providers. The associate chief stated leaders used recruitment and relocation incentives to recruit primary care providers, which had been effective in hiring 20 providers in FY 2024, then later offered incentives to retain them after recruitment incentives ended. The Chief of Staff added the physician recruiter has access to national VA recruiters, which expands their outreach. Additionally, the associate chief stated they used multiple online recruitment venues, and leaders hired residents (physicians in training) after their training program to work as providers. Relationships the Associate Chief of Primary Care had built with local academic affiliates helped the facility recruit the residents.[68]

The Chief Nurse mentioned retaining nurses, rather than recruiting them, in the primary care clinics as a problem. The chief explained that some nurses transferred to other facility positions, such as in care in the community or specialty care and VISN positions in telehealth, which created vacancies. The ADPCS said the overall rate for nursing staff retention in primary care was generally low before FY 2024, but it improved when leaders began offering financial incentives to current employees. In addition, the ADPCS said the facility's Primary Care Team Coordinator trains primary care teams on how to be more productive and efficient, which helped with retention.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[69] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[70]

The OIG reviewed facility data from quarter three of FY 2023 through quarter four of FY 2024 and noted primary care team panel sizes ranged from 82 to 90 percent of VHA's recommended

[67] A licensed vocational nurse has received training from a school of nursing, passed a national licensure examination, and is registered to practice under the direction of a registered nurse or other VA provider. VHA Directive 1108.13(1), *Provision and Use of Nursing Medication Management Protocols in Outpatient Team-Based Practice Settings*, February 6, 2019, amended March 13, 2019.

[68] "An academic affiliate is an educational institution that has a relationship for the purpose of education with a VA medical facility; this relationship is documented by a formal educational affiliation agreement in conformance with VA requirements." VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

[69] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[70] VHA Directive 1406(2).

size.[71] The Patient Centered Management Module Coordinator reported maintaining open communication with primary care leaders about panel size changes and sending them a monthly report to review and provide feedback on suggested adjustments.[72]

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[73] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

During interviews, primary care staff said they feel supported by leaders and their workload is manageable. Both primary care staff and leaders attributed the satisfactory workload to good communication when a team member needs additional assistance. Staff added that each primary care team is paired with another to cover each other when a staff member is absent and allow each team member to have dedicated weekly administrative time (work hours to address nonclinical duties), which helps to manage the workload.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG noted a 4.7 percent increase in veteran enrollment from the end of FY 2022 through August 2024, and the Associate Chief of Staff of Primary Care attributed the increase to the PACT Act. The associate chief added that facility outreach and media coverage increased veterans' awareness of the act, which prompted them to enroll. Additionally, during the site visit, the OIG observed a large informational banner at the entrance of the building to alert veterans to the PACT Act. Primary care staff reported the PACT Act did not cause a noticeable increase in their workload.

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

[71] The baseline capacity of patients a primary care team is expected to care for is 1,200. VHA Directive 1406(2).

[72] "PCMM [Patient Centered Management Module] is a VHA Web-based application that allows input of facility specific and PC [primary care] panel specific data." VHA Directive 1406(2).

[73] VHA Handbook 1101.10(2).

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[74]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[75] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[76] The program did not meet the HCHV5 target from FY 2022 through FY 2024.

The HCHV Program Supervisor stated the COVID-19 pandemic was a barrier to enrollment in FYs 2022 and 2023, explaining that many community partners had shut down and only slowly reopened. To identify homeless veterans, the Homeless Program Manager said staff conduct street outreach and meet with community partners, such as public housing authorities and homeless coalitions, each week. Staff stated another barrier to enrollments is related to culture. They explained that families and friends in the local Latino community often allow homeless individuals to stay overnight in their home, which may preclude veterans from meeting VA's definition for homelessness.[77]

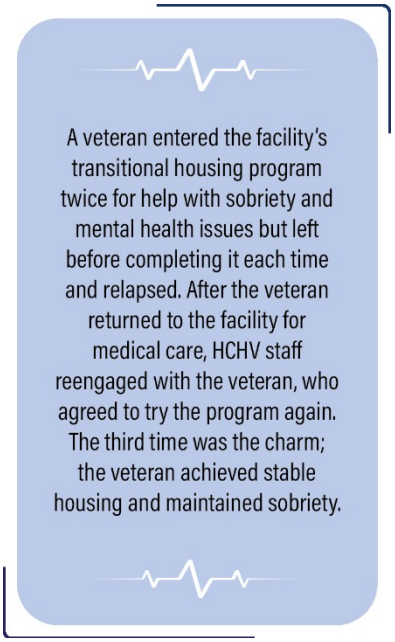

Figure 9. *Best practice for veteran engagement.*
Source: OIG analysis of interview.

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

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

[76] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

[77] VHA defines a homeless individual as "an individual or family without a full-time or adequate nighttime residence." "VA Homeless Programs, VA Homeless FAQs," Department of Veterans Affairs, accessed December 20, 2024, https://www.va.gov/Homeless/faqs.definition.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[78]

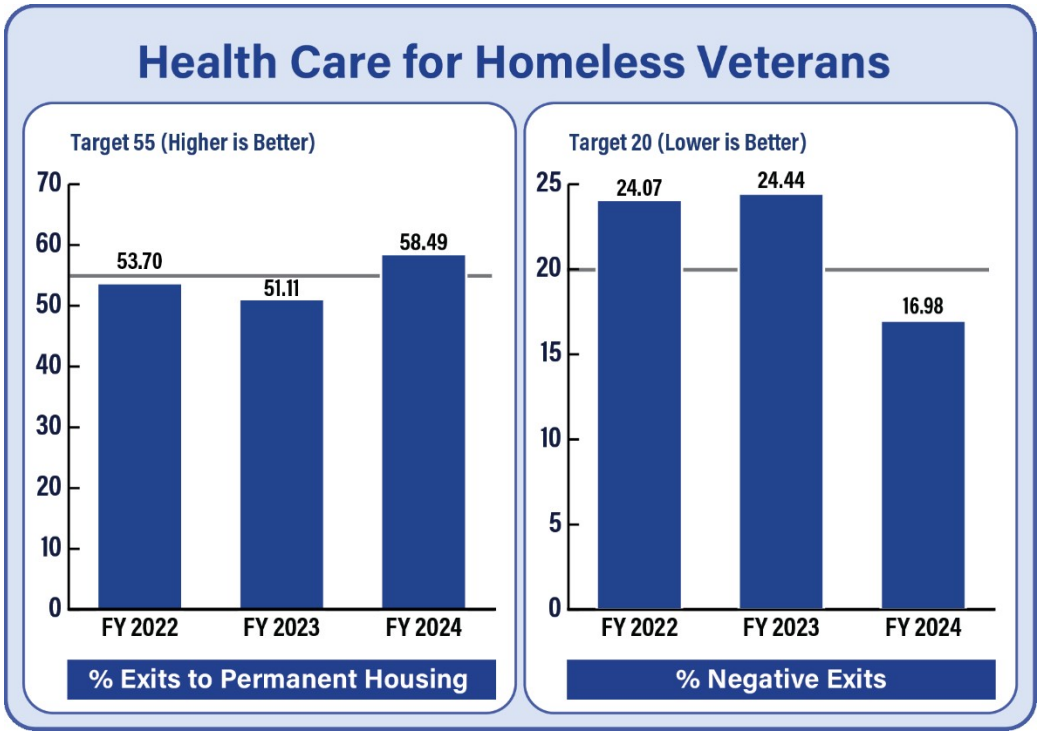

Figure 10. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The program did not meet the HCHV1 targets in FYs 2022 and 2023 but did meet the target in FY 2024. The Homeless Program Manager explained they did not meet the target in FYs 2022 and 2023 because veterans who entered transitional housing did not use it as a stepping stone to permanent housing. The manager also stated that others left transitional housing without informing staff of their plans, which made it difficult for the program to meet the target.

Likewise, the program missed the HCHV2 target in FYs 2022 and 2023 but met it in FY 2024. The Homeless Program Manager and HCHV Program Supervisor explained that because of the small number of contract residential beds, when even a few veterans left without notice or before acquiring permanent housing, it negatively affected the performance metric. The manager said

[78] VHA sets targets for HCHV1 and HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

staff work with veterans with substance use issues who violate transitional housing program rules to find opportunities for them to enter a substance use residential treatment program.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[79] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[80]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[81] The program did not meet the target in FY 2022 but did meet targets in FYs 2023 and 2024. The Homeless Program Manager told the OIG that coordinating with public housing authorities and community partners helped them achieve this success. The manager explained the program covers a large rural area with 21 public housing authorities, and in July 2023, leaders signed a formal agreement with one of the authorities so staff can complete the intake process on-site and issue housing vouchers the same day. The manager also said Corpus Christi public housing authority staff travel to the facility to meet with veterans and issue vouchers.

The manager also discussed performance barriers such as limited housing availability and lack of services for veterans with serious medical needs. To address housing challenges, staff attend community landlord fairs, monitor websites for affordable housing, and work closely with community partners to engage new landlords. To help with medical needs, staff refer veterans to

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

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

[81] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

VA Homemaker and Home Health Aide programs and coordinate with primary care social workers to initiate Texas Medicaid applications for in-home personal care services.[82]

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[83] The program met the target in FYs 2022 through 2024.

The Homeless Program Manager stated when veterans enroll in the program, staff enter information about their employment status into a national data system, and the program's two employment specialists contact those who are identified as unemployed or seeking employment. The HCHV Supervisor stated employment specialists maintain strong partnerships with community employers and help veterans build resumes. Additionally, the supervisor told the OIG that agencies offer computer classes to veterans to develop job skills. One staff member described connecting a veteran to the Association for the Advancement of Retired Persons of Texas, which helped the veteran apply for and obtain a job on the same day. The manager said the employment specialists are also certified to help veterans apply for disability benefits when indicated.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[84] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[85]

[82] "A Homemaker and Home Health Aide is a trained person who can come to a Veteran's home and help the Veteran take care of themselves and their daily activities." "Homemaker and Home Health Aide Care," Department of Veterans Affairs, accessed December 23, 2024, https://www.va.gov/Homemaker_and_Home_Health_Aide_Care. Medicaid is state-administered health coverage for "low-income adults, children, pregnant women, elderly adults and people with disabilities." "Medicaid," Centers for Medicare & Medicaid Services, accessed December 20, 2024, https://www.medicaid.gov/medicaid/index.html.

[83] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

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

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

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[86] The program met the target for FYs 2023 and 2024. The Homeless Program Manager reported receiving referrals from community partners such as jails, veterans treatment courts, and police departments.[87] To engage veterans, program staff visit jails, participate in community mental health alliances and local coalitions, and attend community resource fairs. Staff described strong relationships with law enforcement agencies and community crisis intervention teams. The manager stated the program received approval for two peer specialist positions; one was hired in December 2024, the other was in the hiring process at the time of the OIG site visit.

Meeting Veteran Needs

The Homeless Program Manager reported staff participated in four veterans treatment courts. A Veterans Justice Outreach Specialist described a pending agreement between the facility and the local legal aid organization to provide legal services to veterans for civil matters. The Homeless Program Manager also shared a success story about a veteran experiencing financial stressors, family issues, and homelessness who enrolled in a veterans treatment court. The veteran worked with the facility's housing programs, obtained employment, completed residential treatment for substance use, and met all the requirements to graduate from the court program.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

[86] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[87] "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.

OIG Recommendations and VA Responses

Recommendation 1

Facility leaders identify barriers to providers completing toxic exposure screenings and implement actions to ensure providers complete screenings within 30 days of initiation.

_X_ Concur

____ Nonconcur

Target date for completion: February 6, 2026

Director Comments

The Associate Chief of Staff for Primary Care and the Deputy Chief of Staff for Primary Care are responsible for this action. The Primary Care Office will collaborate with the Chief of Health Administration Services (HAS) and other Specialty Service Chiefs to assist with the backlog of Toxic Exposure Screening (TES) reminders to help with the identified barrier of time constraints by Primary Care providers. The Primary Care Office will also partner with Veterans Exposure Team – Health Outcomes Military Exposures (VET HOME) for immediate resolution of unresolved stage 2 TES's and engage with the TES-Navigator Field Advisory Committee and will follow up with a meeting for process improvement. System Redesign will be included as well for assistance with the process improvement and sustainment.

A monthly VHA Support Service Center Capital Assets (VSSC) TES Screening report will be extracted with the numerator being the # of screenings completed within 30 days and the denominator being the total number of TES screenings due. The goal is to reduce the percentage Stage Two not complete from 5% to 1 % (national VA average). Audit findings will be reported in the PACT Steering Committee through the Clinical Executive Board until the goal is maintained for six consecutive months.

OIG Comments

The OIG considers this recommendation open until sufficient evidence demonstrates sustained improvement.

Recommendation 2

Facility leaders ensure each service has a service-level workflow for test result communication that is consistent with VHA requirements.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Deputy Chief of Staff is responsible for this action. The Deputy Chief of Staff has reviewed and amended MCP 11-24-100(1), Communicating Test Results to Providers and Patients, to ensure the service-level workflow for test result communication includes services and standard timeframes for high-risk patients consistent with VHA requirements via Appendices of the MCP. The MCP 113-21-08(1) was also amended to include a cascade for lab staff to use for the notification of actionable (critical) test results. The Facility is requesting a one-time closure for this recommendation.

OIG Comments

The reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Recommendation 3

The Director ensures the Chief of Staff attends Peer Review Committee meetings.

_X_ Concur in principle

____ Nonconcur

Target date for completion: Completed

Director Comments

While the facility concurs in principle, the Chief of Staff is responsible for this action. VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018, Appendix A, 1. Compositions and Qualifications for the Peer Committee Membership states, "In the occasional absence of the Chief of Staff, a designee may be appointed". The Peer Review Committee minutes will now explicitly state who is the Acting Delegate in the Chief of Staff absence. The Chief of Quality Management reviewed the FY 25 Peer Review Committee minutes attendance roster, validating the committee having been chaired by the Chief of Staff in Qtrs. 1-3 with 1 appointed and identified delegate (Deputy COS) to Chair the committee in May 2025, meeting VHA requirements. The Facility is requesting a one-time closure for this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to VSOs. Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from December 10 through 12, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

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

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

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

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

scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 31, 2025

From: Director, VA Heart of Texas Healthcare Network (10N17)

Subj: Healthcare Facility Inspection of the VA Texas Valley Coastal Bend Healthcare System in Harlingen

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

Director, GAO/OIG Accountability Liaison (VHA 10OIC GOAL Action)

Thank you for this opportunity to respond to this Healthcare Facility Inspection at VA Texas Valley Coastal Bend Healthcare System in Harlingen.

I have reviewed and concur with the findings, recommendations, and action plans submitted.

(Original signed by:)

Jamie Park, Ed.D
Deputy Network Director, VISN 17
for
Wendall Jones, M.D., M.B.A.
Network Director, VISN 17

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 24, 2025

From: Director, VA Texas Valley Coastal Bend Healthcare System (740)

Subj: Healthcare Facility Inspection of the VA Texas Valley Coastal Bend Healthcare System

To: Director, VA Heart of Texas Healthcare Network (10N17)

I have reviewed the VA OIG Draft Report: Healthcare Facility Inspection of the VA Texas Valley Coastal Bend Healthcare System in Harlingen, Texas, and I concur with 2 of the recommendations regarding Toxic Exposure Screenings not completed within 30 days of initiation and Service-Level Workflow not consistent with VHA requirements, and the facility responses provided for each.

In principle, I concur with the Peer Review Committee finding as the VHA Directive 1190, Peer Review for Quality Management, dated November 21, 2018, Appendix A, 1. Compositions and Qualifications for the Peer Committee Membership states, “In the occasional absence of the Chief of Staff, a designee may be appointed”. The Peer Review Committee minutes will now explicitly state who is the Acting Delegate in the Chief of Staffs’ absence.

I am submitting to your office as requested.

(Original signed by:)

Homero S. Martinez III, MBA
Medical Center Director

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Director, VA Texas Valley Coastal Bend Healthcare System (740)

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