US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the South Texas Veterans Health Care System in San Antonio

Healthcare Facility Inspection	25-00192-15	December 10, 2025

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors. 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 South Texas Veterans Health Care System (facility) from January 13 through 16, 2025.[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. In an interview, executive leaders described intravenous fluid shortage, sterilization equipment replacement, and sterile processing operations moving to a mobile unit as system shocks.[2] Leaders said they delayed several surgeries when the fluid shortage occurred in September 2024, after Hurricane Helene.[3] They shared fluid with local community and military health systems to jointly support each other, which reduced surgical delays.

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

[2] The Sterile Processing Service handles the reprocessing of devices that can be "reused on multiple patients" at a VA medical facility. VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[3] In September 2024, Hurricane Helene caused extensive damage to the largest manufacturer of intravenous solution in the United States, and the Centers for Disease Control and Prevention recommended that all healthcare providers assess their supply and develop plans to reduce the effect on patients. "Disruptions in Availability of Peritoneal Dialysis and Intravenous Solutions from Baxter International Facility in North Carolina," Centers for Disease Control, accessed February 27, 2025, https://www.cdc.gov/healthcare/shortage.

Executive leaders also described how they moved all sterile processing operations to a mobile unit in October 2023, after staff found black debris in sterile processing trays the prior month. VHA's national Office of Sterile Processing reviewed the issue and provided recommendations to executive leaders that included replacing equipment.[4] Leaders moved sterile processing services, replaced equipment, and offered veterans the choice to schedule non-emergency procedures in the community.[5]

Leaders said there were no adverse patient events because of these sterile processing issues, and the OIG found no notable increase in infection rates after leaders moved sterile processing operations to a mobile unit. Executive leaders had a contract for the mobile unit until September 2025 but did not know when they would return to normal operations.

Despite these challenges, the OIG noted the facility's All Employee Survey scores related to communication remained consistently above the VHA average.[6] Executive leaders said they maintained high levels of communication and shared information through weekly newsletters, executive leaders' visits to staff in their work areas, and virtual discussion boards. Further, OIG questionnaire respondents described executive leaders' communication as clear and useful.

Executive leaders also highlighted staff's engagement in VA's mission and emphasis on a Just Culture through the facility's employee enrichment committee, where staff organized veteran-centric events, as well as its Patient Safety Program of Excellence designation in April 2024.[7] Additionally, VA All Employee Survey data show the facility's psychological safety scores remained consistently above the VHA average from fiscal years (FYs) 2022 through 2024.[8] Staff

[4] The Office of Sterile Processing "provides consultative oversight and guidance for improvement of Sterile Processing Services…operations and practices…across the nation." "The Office of Sterile Processing (OSP)," Department of Veterans Affairs, accessed January 22, 2025, https://www.patientcare.va.gov/Sterile_Processing.

[5] VHA offers veterans care in the community when it "cannot provide the care needed. This care is provided on behalf of and paid for by VA." "Community Care," Department of Veterans Affairs, accessed January 30, 2025, https://www.va.gov/COMMUNITYCARE.

[6] 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.

[7] "A Just Culture recognizes that even the most committed professionals will make mistakes" and is "focused on the 'why' and not the 'who'" when those events happen. "NCPS [National Center for Patient Safety] Approach to Achieving High Reliability," VHA National Center for Patient Safety, accessed February 4, 2025, https://www.patientsafety.va.gov/Approach_To_Achieving_High_Reliability.asp. Assistant Under Secretary for Health for Quality and Patient Safety (17), "Informational: 2024 NCPS Patient Safety Program of Excellence (VIEWS 11062124)," memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), November 21, 2023.

[8] "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.

submitted the second highest number of patient safety reports in the Veterans Integrated Service Network for FY 2024.[9]

In the OIG questionnaire, a patient advocate said veterans' three most common complaints were changes in medical providers, ineffective care coordination, and delayed phone call responses.[10] Executive and facility leaders said to address complaints they explained the reason for provider changes to veterans, developed a process for staff to better respond to veterans' calls, and planned to create an integrated practice unit to improve communication between staff in different services.

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 facility includes Kerrville VA Medical Center and the Audie L. Murphy Memorial Veterans' Hospital. The OIG inspected both sites and observed clear signs at the main entrances, navigation assistance, and other tools to help veterans with visual and hearing impairments.

The OIG found problems with staff monitoring the temperature for medication refrigerators, maintaining cleanliness in patient care areas, and ensuring clean storage areas were free of dirty items and equipment. The OIG made a recommendation to address cleanliness and storage issues, but did not issue one for temperature monitoring, since staff corrected the problem while the OIG was at the facility in January 2025. In response to the recommendation, the Director reported that leaders will inspect storage and patient care areas weekly to ensure they are clean.

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. VHA requires medical facilities to develop service-level workflows that describe the role of various team members in the test result communication process.[11] However,

[9] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed May 21, 2025, https://www.va.gov/HEALTH/visns.asp.

[10] 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/.

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

the OIG found facility staff had created workflows for only one service. The OIG made a recommendation to ensure compliance with the requirement. In response, the Director stated staff are actively developing workflows for all services.

The latest OIG and Joint Commission reports did not contain any open recommendations related to test result communications.[12] During interviews, the OIG learned that the Internal Readiness Committee actively monitored corrective action sustainment, and leaders supported process improvement initiatives. Leaders described a recent project that reduced ventilator-associated pneumonia cases.[13]

Primary Care

The OIG determined whether 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]

Most of the vacancies in the facility's Primary Care Service were among providers. The OIG found leaders actively addressed the challenge by offering bonuses, relocation incentives, and education loan repayment.

The OIG examined panel sizes (the number of patients assigned to a primary care team) and found most facility panel averages exceeded VHA expectations.[15] The OIG also noted a recent increase in veteran enrollment. Further, new patients waited 30 days on average for an appointment and in many instances, providers are not allocated the minimum recommended number of exam rooms. However, the OIG found leaders continued to stabilize panel sizes and provide timely access to veterans by hiring staff and planning to expand facility space. Therefore, the OIG did not issue a recommendation.

[12] VA OIG, *Comprehensive Healthcare Inspection of the South Texas Veterans Health Care System San Antonio*, Report No. 22-00040-115, May 17, 2023; The Joint Commission, *Final Accreditation Report South Texas Veterans Health Care System*, April 11, 2024.

[13] Ventilator-associated pneumonia is a lung infection occurring in a patient more than 48 hours after mechanical ventilation has been started. Steven M. Koenig and Jonathon D Truwit, "Ventilator-associated Pneumonia: Diagnosis, Treatment, and Prevention," *Clinical Microbiology Reviews* 19, no. 4 (2006), https://doi.org/10.1128/cmr.00051-05.

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

[15] The maximum number of patients a primary care team is expected to care for at baseline is 1,200. The number is adjusted to consider primary care team "support staff, rooms, female veterans, intensity score, and PCP [primary care provider] type." VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 17, 2025.

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 into the programs and how well they meet veterans' needs. The OIG found the facility had active homeless programs with adequate staffing. Program staff worked closely with community partners to identify homeless veterans and provide them with services and resources. Staff highlighted the Contracted Emergency Residential Services temporary housing facility, which could accommodate up to 35 male and 6 female veterans each day; each veteran could stay for up to 90 days.[16] However, the facility did not meet the target to permanently house these veterans in FYs 2023 and 2024. The program coordinator attributed missing the target to some veterans' inability to transition to permanent housing because of complex mental health issues.

The Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet the performance target for the percentage of housing vouchers assigned to the facility used by veterans or their families. The program coordinator attributed this to a severe staffing shortage at the largest public housing authority in the service area, which delayed voucher processing. To overcome this obstacle, program staff collaborated with Veterans Integrated Service Network leaders and the public housing authorities to streamline processes and enhance communication.

The OIG found the facility exceeded targets for the number of veterans entering the Veterans Justice Program for FYs 2023 and 2024. Program staff effectively enrolled veterans, conducted multiple outreach events, built strong community partnerships with law enforcement agencies, and educated stakeholders about VA resources including medical, mental health, military sexual trauma, and interpersonal violence services.

What the OIG Recommended

The OIG made two recommendations.

1. The Associate Director for Operations ensures staff keep patient care areas clean and clean storage areas free of dirty items and equipment.
2. The Chief of Staff ensures the facility has workflows for all services to identify team members' roles in the test result communication process.

[16] "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans, and leaders are implementing corrective actions (see OIG Recommendations and VA Responses and appendixes C and D for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
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

South Texas Veterans Health Care System
San Antonio, Texas
Level 1a-High Complexity
Bexar County
Hospital Referral Region: San Antonio

Description of Community

POPULATION

Female **2,568,946**	Male **2,563,321**
Veteran Female **48,236**	Veteran Male **272,653**

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

MEDIAN INCOME

$56,297

EDUCATION

83% Completed High School
50% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **211**

SUBSTANCE USE

23.2% Driving Deaths Involving Alcohol
18.7% Excessive Drinking
860 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	1,783,395
Carpool	242,447
Work at Home	205,457
Walk to Work	46,084
Other Means	43,004
Public Transportation	39,071

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**50.5 Minutes, 48 Miles**
Specialty Care	**87 Minutes, 90 Miles**
Tertiary Care	**93 Minutes, 100 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **56,449**

Veterans Receiving Telehealth (Facility)	54%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	24%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

35,566

695 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.03 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

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

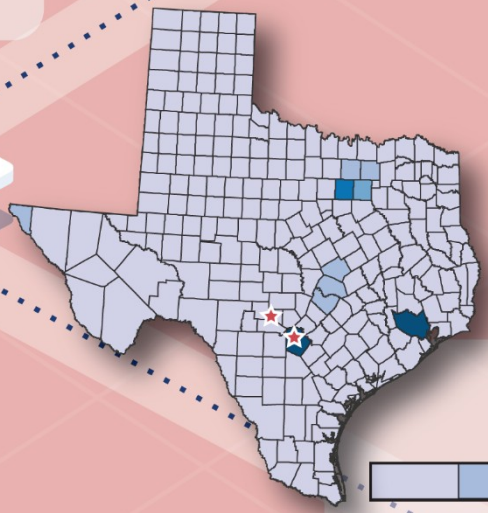
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	124K
Unique Patients VA Care	119K
Unique Patients Non-VA Care	53K

COMMUNITY CARE COSTS

Unique Patient	$23,983
Outpatient Visit	$605
Line Item	$1,063
Bed Day of Care	$250



STAFF RETENTION

Onboard Employees Stay <1 Yr	8.66%
Facility Total Loss Rate	10.09%
Facility Retire Rate	1.86%
Facility Quit Rate	7.20%
Facility Termination Rate	0.97%

★ 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) 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. 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 (VA), "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]

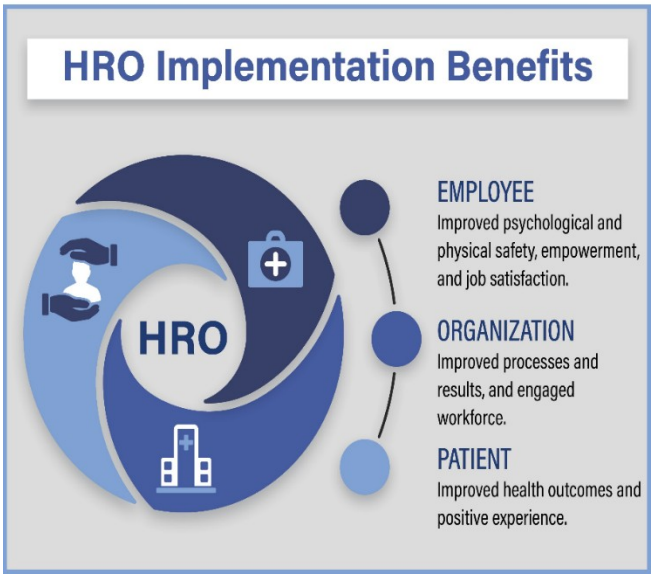

Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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 inspectors observed how facility leaders incorporated high reliability principles into their operations.

[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.

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 Under Secretaries, 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 17, 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 South Texas Veterans Health Care System (facility) includes the Kerrville VA Medical Center (Kerrville) and Audie L. Murphy Memorial Veterans' Hospital (Audie Murphy), which began providing patient care in 1923 and 1973, respectively. It also has several community-based outpatient clinics in the service area. The facility had 484 operating beds (233 hospital, 185 community living center, and 66 domiciliary), and a fiscal year (FY) 2024 budget of approximately $1.7 billion.[13]

The OIG inspected the facility from January 13 through 16, 2025. Executive leaders consisted of the Executive Director (Director), Deputy Medical Center Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director for Operations, Associate Director for Resources, and Acting Assistant Director.

A 2018 study of struggling VA and non-VA healthcare systems in multiple countries and settings 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] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed April 28, 2025, https://www.va.gov/VA_Community_Living_Centers.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp.

[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] 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]

Figure 4. *System shocks. Source: OIG interview with executive and facility leaders.*

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. In an interview, executive leaders identified a national shortage of intravenous fluid, the replacement of sterilization equipment, and relocation of sterile processing operations as system shocks.[19]

The executive leaders reported delaying several surgeries in September 2024 due to the intravenous fluid shortage.[20] The leaders shared intravenous fluid between local military and community providers, which reduced surgical delays. The Chief of Staff stated the facility's intravenous fluid supply improved because of this action.

The OIG reviewed documents provided by facility leaders and learned that in late September 2023 operating room staff found black debris at the bottom of sterile trays, which was caused by the sterilization equipment. Executive and facility leaders requested consultation from VHA's national Office of Sterile Processing to address the issue.[21] The Office of Sterile Processing reviewed the issue from October 3 through 5, 2023, and provided recommendations related to sterilization equipment, local water chemistry testing and monitoring, and staff

[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 Sterile Processing Service handles the reprocessing of devices that can be "reused on multiple patients" at a VA medical facility. VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[20] In September 2024, Hurricane Helene caused extensive damage to the largest manufacturer of intravenous solution in the United States, and the Centers for Disease Control and Prevention recommended that all healthcare providers assess their supply and develop plans to reduce the effect on patients. "Disruptions in Availability of Peritoneal Dialysis and Intravenous Solutions from Baxter International Facility in North Carolina," Centers for Disease Control and Prevention, accessed February 27, 2025, https://www.cdc.gov/shortage-of-dialysis-solutions.

[21] The Office of Sterile Processing "provides consultative oversight and guidance for improvement of Sterile Processing Services…operations and practices…across the nation." "The Office of Sterile Processing (OSP)," Department of Veterans Affairs, accessed January 22, 2025, https://www.patientcare.va.gov/SterileProcessing.

knowledge. The OIG found executive and facility leaders developed action plans to address the issues, which included relocating sterile processing operations to a mobile unit in October 2023.

Facility staff performed only emergency surgeries and procedures while transitioning to the mobile unit. Executive leaders explained they gave veterans the choice to schedule nonemergency procedures in the community, and ensured staff rescheduled veterans' procedures if they chose to wait and have the procedure at the facility.[22] Furthermore, an executive leader said veterans had no adverse outcomes. The OIG reviewed FYs 2023 and 2024 post-surgical infection rates and found no notable increase after leaders moved operations to the mobile unit.

During the inspection, the OIG noted the sterile processing operations remained in a mobile unit. Executive leaders could not provide the OIG with an expected date to return to normal operations due to ongoing abnormal water chemistry results and the need to replace additional sterilization equipment. However, they have a contract to continue using the mobile unit until September 2025.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[23] 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 culture.[24] 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."[25]

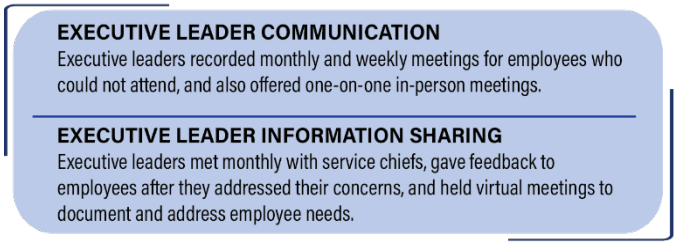

Figure 5. *Executive leaders' communication with staff. Source: OIG interview with executive and facility leaders.*

[22] VHA offers veterans care in the community when it "cannot provide the care needed. This care is provided on behalf of and paid for by VA." "Community Care," Department of Veterans Affairs, accessed January 30, 2025, https://www.va.gov/COMMUNITYCARE/programs.

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

[24] 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*.

[25] 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.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with employees, and shared information.[26] The OIG found the survey scores for executive leader communication, transparency, and information sharing remained consistently above VHA averages for FYs 2022 through 2024.

Executive leaders said they use multiple methods to engage with employees and share information effectively, including

- weekly newsletters,
- weekly and monthly virtual meetings,
- visits to work areas, and
- a virtual message board called *Speak to the Director* for a two-way dialogue between employees and the Director.

A facility leader explained that these actions had been effective because employees did not indicate communication was one of their top three priorities in the FY 2024 All Employee Survey. Additionally, most respondents to the OIG questionnaire described executive leaders' communication as clear and useful.

[26] 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.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28] 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.

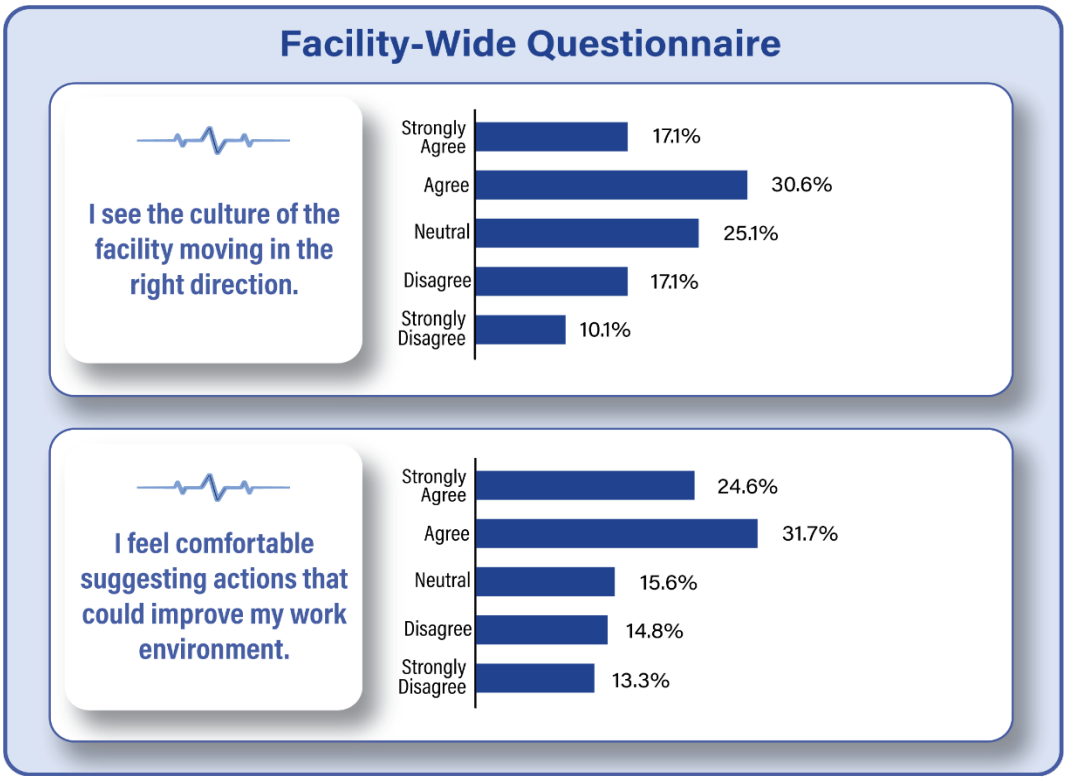

Figure 6. *Employees' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The OIG found psychological safety scores remained consistently above the VHA average from FYs 2022 through 2024. Most OIG questionnaire respondents also indicated they felt comfortable reporting patient safety concerns, which was consistent with the All Employee Survey results. Executive leaders attributed these scores to two factors: employee

[27] "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.

[28] 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.

engagement and their focus on a Just Culture.[29] Executive leaders said employee engagement started with their commitment to VA's mission of caring for veterans. They also said employees volunteered to serve on an enrichment committee and in events, such as Wreaths Across America, which indicated they were highly engaged.[30]

Also, executive and facility leaders said employees' Just Culture focus led to the facility receiving a Patient Safety Program of Excellence designation from VHA in April 2024.[31] The designation showed the facility's commitment to patient safety, empowerment of employees, and focus on accountability. Executive leaders explained they created a safe space for employees to admit mistakes, coached service leaders on how to support those who made them, and developed peer support groups to connect employees with someone who had gone through the same experience.

Notably, employees submitted the second highest number of patient safety reports in Veterans Integrated Service Network (VISN) 17 for FY 2024.[32] A facility leader said the high number of reports resulted from a focused effort to ensure employees knew how their contribution improved the facility. The leader also stated most of the patient safety reports were close calls (events that did not cause harm), which suggested employees felt psychologically safe.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[33] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[34] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility. In response to an OIG questionnaire, a patient advocate indicated

[29] "A Just Culture recognizes that even the most committed professionals will make mistakes" and is "focused on the 'why' and not the 'who'" when those events happen. "NCPS [National Center for Patient Safety] Approach to Achieving High Reliability," VHA National Center for Patient Safety, accessed February 4, 2025, https://www.patientsafety.va.gov/features/NCPS_Approach_To_Achieving_High_Reliability.asp.

[30] Wreaths Across America is a nonprofit organization that annually lays wreaths "on the headstones of our nation's service members" with a mission to "Remember the fallen. Honor those who serve. Teach the next generation the value of freedom." "Our Mission," Wreaths Across America, accessed February 4, 2025, https://www.wreathsacrossamerica.org/About/OurMission.

[31] Assistant Under Secretary for Health for Quality and Patient Safety (17), "Informational: 2024 NCPS Patient Safety Program of Excellence (VIEWS 11062124)," memorandum to Veterans Integrated Service Network (VISN) Director (10N1-23), November 21, 2023.

[32] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed May 21, 2024, https://www.va.gov/HEALTH/visns.asp.

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

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

veterans' most common complaints were medical provider changes, ineffective care coordination, and delayed phone call responses.

The Director explained that many medical providers have changed because of staff turnover and increased veteran enrollments at the facility. For example, when medical trainees graduate and leave the facility, staff reassign veterans to new providers. An executive leader also mentioned they used temporary medical providers to care for newly enrolled veterans during evening or weekend clinics. As a result, veterans typically do not see these temporary providers again after their first appointment. Executive leaders said they informed veterans about why these changes occurred and relied on staff to ensure veterans' care continued without interruption.

Executive leaders shared plans to create an integrated practice unit to address care coordination concerns, such as communication between staff in two services in the facility. This unit will colocate services like physical therapy and orthopedics in one area to improve veterans' experiences during care transitions.

To address delayed phone call responses, a facility leader stated staff improved times by grouping a veteran's messages so they could address all their needs at once. The leader explained that veterans may leave several messages, and multiple staff previously returned each call. By grouping the messages, staff improved response times and reduced duplicate calls. Executive and facility leaders highlighted that FY 2024 veteran trust scores (from VA's VSignals surveys) were consistently near the VHA average of 91.8 percent.[35]

During an interview, executive leaders also stated they worked closely with local, rural, and national VSOs to support veterans. Executive leaders said they met with VSOs quarterly, which increased interactions with rural veterans. They also collaborated with VSOs to provide services, such as health care enrollment, homeless services, and transportation to medical appointments.

[35] VA measures the percentage of veteran respondents who trust VA health care, through surveys sent through the VSignals platform. "Veteran Trust in VA," Department of Veterans Affairs, accessed January 22, 2025, https://www.va.gov/initiatives/veteran-trust-in-va/.

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.[36] 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 7. *Audie L. Murphy Memorial Veterans' Hospital.*
Source: Photo provided by the Chief, Public Affairs.

Figure 8. *Kerrville VA Medical Center.*
Source: Photo provided by the Chief, Public Affairs.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[37] 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.[38]

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[36] VHA Directive 1608(1).

[37] 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.

[38] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

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.

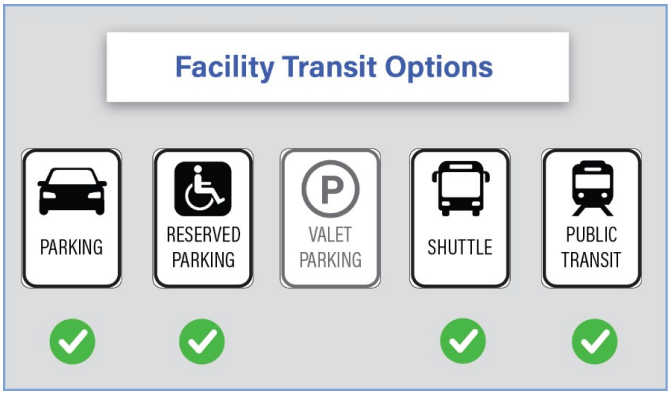

Figure 9. *Transit options for arriving at the facilities. Source: OIG analysis of documents and interviews.*

The OIG used a navigation link on the facility's website and a phone application to accurately navigate to the Kerrville and Audie Murphy sites. The OIG observed that employee and visitor parking lots at both locations included spaces accessible for those with disabilities, adequate lighting, and staff reported that a police-controlled robot patrols the parking areas. Facility staff provided information that shows public transit is available to transport veterans to the Audie Murphy location. Shuttles and golf carts are also available at this location to move veterans around the site.[39]

The OIG noted Kerrville is a smaller site that did not offer local shuttle services, and it is in a remote area that does not have public transit. However, there are shuttles that transport veterans between the Audie Murphy and Kerrville sites.

[39] Shuttle service was available Monday through Friday (excluding holidays) at the Audie L. Murphy Memorial Veterans' Hospital from approximately 7:00 a.m. to 4:45 p.m., and at the Northwest San Antonio VA Clinic from approximately 8:00 a.m. to 3:45 p.m.

Main Entrance

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.[40]

The OIG observed the main entrances at both the Kerrville and Audie Murphy locations featured clear signs, a designated passenger loading zone, power-assisted doors with wheelchair ramps, and volunteers generally available to assist with navigation and wayfinding. Both main entrances were also well lit and had sufficient seating areas.

Figure 10. *Audie L. Murphy Memorial Veterans' Hospital main lobby.*
Source: Photo taken by facility staff.

Figure 11. *Kerrville VA Medical Center.*
Source: Photo taken by facility staff.

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.[41]

[40] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

[41] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[42] OIG questionnaire respondents reported that those with hearing loss have access to remote interpretation services and assistive listening devices, such as a personal sound amplifier. Staff explained they help veterans with visual impairments by describing the surroundings and escorting them within the facility. In addition, the facility has a team that contacts visually impaired veterans ahead of time to coordinate support and provide escorts on arrival.

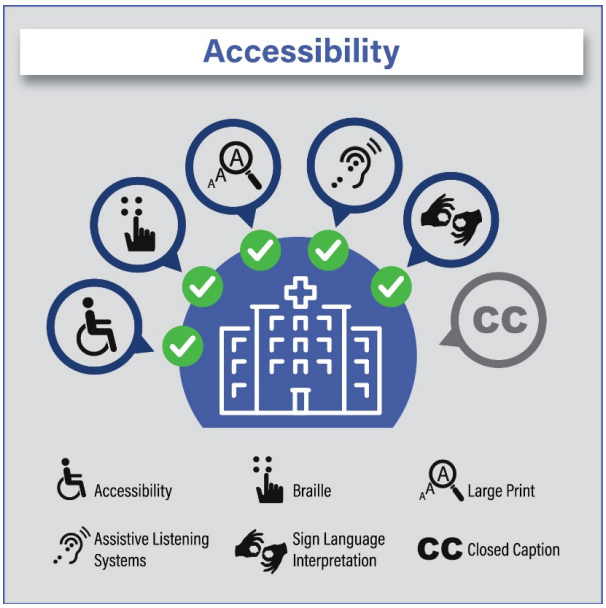

Figure 12. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

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.[43]

During inspections at the Audie Murphy location, the OIG observed a volunteer-staffed welcome center where veterans can obtain handouts on topics such as toxic exposure screenings. The OIG also noted flyers with similar information at the primary care clinic area at the Kerrville site.

In response to an OIG questionnaire, one of the two assigned navigators said staff inform veterans about screenings during primary care visits, where most screenings take place. The navigator reported approximately 1,650 overdue secondary screenings (conducted when a veteran reports a toxic exposure during an initial screening) and cited competing priorities as a significant factor. For instance, the navigator shared that providers prioritized patient care over completing toxic exposure screenings. The navigator addressed the issue by re-educating providers about the process and notifying them of overdue screenings.

[42] 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.

[43] 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.

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.[44]

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.

The OIG reviewed the facility's most recent Annual Workplace Evaluation Report, which cited improper use of power strips.[45] The Comprehensive Environment of Care Coordinator discussed their performance improvement project on electrical safety issues and plans to reinforce safety issues with staff at meetings. The OIG did not observe multiple electrical cords connected in a serial fashion in the areas inspected.

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.

The OIG found staff did not monitor medication refrigerators' temperatures in two areas at the Audie Murphy site and one at Kerrville.[46] VHA requires staff to monitor refrigerators that store medications to ensure the temperatures meet the Centers for Disease Control and Prevention recommendations.[47] Pharmacy staff reported they were familiar with the requirements but unaware no one had monitored the refrigerators. While the OIG was on-site, facility staff connected an electronic device that tracks the temperature to ensure they continuously monitor the refrigerators. The OIG acknowledges the steps taken by staff to correct the oversight and therefore did not make a recommendation.

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

[45] The Annual Workplace Evaluation is a yearly Occupational Safety and Health compliance inspection and program evaluation conducted by VISN staff. VHA Directive 7701, *Comprehensive Occupational Safety and Health Program*, December 12, 2022.

[46] The OIG found the unmonitored refrigerators in medication rooms in the Audie Murphy Medical Intensive Care Unit and Community Living Center, and Kerrville Community Living Center.

[47] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

The OIG observed dirty floors and refrigerator door seals in patient care areas.[48] The OIG also observed that clean storage areas contained dirty items and equipment.[49] The Joint Commission requires healthcare facilities to maintain a clean environment to avoid infection sources and transmission.[50] The Quality Management Consultant said they were unaware the refrigerator seals were dirty, and attributed the dirty floors to staff's lack of attention to detail. Facility leaders reported an absence of staff education regarding separating clean and dirty items and properly tagging equipment. The OIG recommended the Associate Director for Operations ensures staff keep patient care areas clean and clean storage areas free of dirty items and equipment. In response, the Director reported that the Associate Director for Operations, Environmental Management Services, and nursing leaders will inspect clean storage areas, refrigerator seals, and floors weekly to ensure they are clean (see OIG Recommendations and VA Responses).

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.[51] 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.[52]

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. The

[48] The OIG found dirty refrigerator seals in the Kerrville Community Living Center and Audie Murphy Emergency Department and Medical Surgical unit. The OIG also found dirty floors in the Audie Murphy Community Living Center.

[49] The OIG found deficiencies in the following areas: the Kerrville Community Living Center and Audie Murphy Emergency Department and Community Living Center.

[50] The Joint Commission, *Standards Manual,* E-dition, IC.06.01.01, March 30, 2025.

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

[52] 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.

OIG found facility leaders had established processes to inform providers about urgent, noncritical test results; follow up on the results with patients; assign a substitute when providers who order tests are unavailable or left the facility; and transmit results outside of regular clinic hours and during care transitions.

Leaders said they oversee compliance with test result communications to both providers and patients through an External Peer Review Program.[53] Quality management leaders report the results to executive leaders quarterly and collaborate with them to address any deficiencies.

The OIG requested service-level workflows that outline team members' roles in the test result communication process, and staff provided workflows for only one service. VHA requires facilities to have workflows for each service.[54] The OIG recommended the Chief of Staff ensures the facility has workflows for all services to identify team members' roles in the test result communication process. In response, the Director indicated that staff are actively developing these service-level workflows (see OIG Recommendations and VA Responses).

Action Plan Implementation and Sustainability

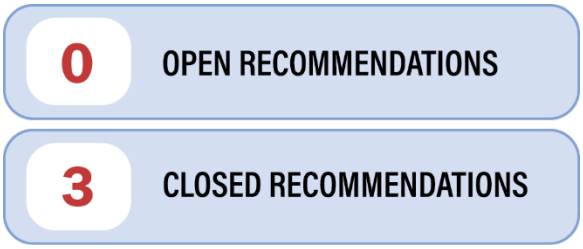

Figure 13. *Status of prior OIG recommendations. Source: VA OIG.*

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 hallmarks of an HRO.[55] 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 had no open recommendations regarding test result communication to providers and patients in the latest OIG and Joint Commission reports.[56] Facility leaders attributed their success in implementing action plans and sustaining improvements to the Internal Readiness Committee. They explained the committee meets monthly and uses a dashboard that displays real-time data to monitor adherence to the plans.

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[53] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

[54] VHA Directive 1088(1).

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

[56] VA OIG, *Comprehensive Healthcare Inspection of the South Texas Veterans Health Care System San Antonio*, Report No. 22-00040-115, May 17, 2023; The Joint Commission, *Final Accreditation Report South Texas Veterans Health Care System*, April 11, 2024.

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.[57] 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.[58] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Leaders said staff usually develop process improvement activities in response to events entered into the Joint Patient Safety Reporting system, a web-based tool VHA employees use to report patient safety incidents.[59] The Patient Safety Manager explained that staff carefully review the reports to assess the level of harm caused by each event. Then, the Patient Safety Manager assigns staff to investigate the event and implement corrective actions to improve patient safety.

During an interview, facility leaders shared a successful process improvement project. Leaders said infection prevention staff identified increased numbers of patients with ventilator-associated pneumonia, which significantly increased the length of stays in the intensive care unit.[60] To reduce these cases and the length of stays, leaders implemented rapid rounds in the intensive care unit. Staff described rapid rounds as daily interdisciplinary team meetings of doctors, nurses, pharmacists, and respiratory therapists, who assess patients and discuss care plans to determine appropriate treatments. Facility leaders highlighted that the project was successful, and they shared it with staff through an internal online publication called Monday Minute, demonstrating their commitment to continuous process improvements.

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

[58] VHA Directive 1050.01(1).

[59] VHA Directive 1050.01(1).

[60] Ventilator-associated pneumonia is a lung infection occurring in a patient more than 48 hours after mechanical ventilation has been started. Steven M. Koenig and Jonathon D. Truwit, "Ventilator-associated Pneumonia: Diagnosis, Treatment, and Prevention," *Clinical Microbiology Reviews* 19, no. 4 (2006), https://doi.org/10.1128/cmr.00051-05.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[61] 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.[62] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[63] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG verified the facility had 182 primary care teams with vacancies for nine providers, seven nurses, and eight administrative associates. Facility leaders said the nursing vacancies did not negatively affect patient care. They also reported no issues with recruiting administrative associates, which was ongoing.

However, a leader and staff said the competitive local healthcare market and VA's lengthy hiring processes caused significant challenges with hiring primary care providers. Leaders said they offer sign-on bonuses, relocation incentives, and education loan repayment options to increase recruitment, which has been effective. Leaders also said limited training for newly onboarded providers caused issues with retention, and 21 of the 24 providers hired in FY 2024 had left due, in part, to this reason. In response, leaders enhanced training for providers.

In an interview, primary care staff stated the high volume of patients, view alerts, and secure messages overwhelmed providers.[64] Pharmacists, nurses, and registered dietitians shared how they work with primary care providers to help reduce their workload:

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

[62] 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).

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

[64] A view alert is an electronic notification in a computerized patient record system designed to alert the user to activities such as reviewing a patient's clinical test results. Department of Veterans Affairs, Office of Information & Technology, *Computerized Patient Record System (CPRS) Technical Manual: List Manager Version*, June 2023.

- Clinical pharmacists respond to view alerts and secure messages about medication management.
- Nurses expedite routine medication refill requests and referrals to specialists and reply to veterans' messages.
- Registered dietitians schedule group education classes to discuss diabetes, weight management, and heart health with veterans, so providers can focus on other goals during appointments.

Facility leaders also said they planned to implement new automated technology to manage laboratory and radiology results to reduce the number of view alerts; they also expanded video telehealth services.[65]

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.[66] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[67]

Primary care staff said the number of patients assigned to each team overwhelmed providers. The OIG reviewed primary care data and noted 13 of 15 clinics had panels that exceeded VHA's expected size.[68] A facility leader said they recognized the need for more primary care teams and worked with human resources personnel to increase staffing.

In many instances, providers are not allocated the minimum recommended number of exam rooms. VHA recommends 2.5 rooms per full-time provider.[69] Executive leaders described strategies to increase space. They planned to lease additional locations, construct new sites, consider mobile units, and expand existing clinics. Another leader stated that new patients waited an average of 30 days for an appointment, when VHA's goal is 20 days.

[65] "Clinical Resource Hubs (CRH) 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 (CRH)," Department of Veterans Affairs, accessed September 18, 2025. https://www.patientcare.va.gov/primarycare/CRH.asp.

[66] "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).

[67] VHA Directive 1406(2).

[68] The maximum number of patients a primary care team is expected to care for at baseline is 1,200. The number is adjusted to consider primary care team "support staff, rooms, female veterans, intensity score. and PCP [primary care provider] type." VHA Directive 1406(2).

[69] VHA Directive 1406(2).

The leaders said they use Saturday clinics and dedicated days for new patient appointments to improve access to care. Because leaders were aware of the issue and had plans to address it, the OIG made no recommendation.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[70] 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.

In the interview, primary care staff shared several nursing process improvement projects that reflected leaders' approach to the facility's Pathway to Excellence designation.[71] One project offered veterans same-day access at all primary care clinics. They also renovated a triage room, realigned various nursing committees, and monitored metrics to improve operations. In addition, facility leaders reported several methods (daily huddles, weekly meetings, town halls, and clinic monthly meetings) for staff to communicate their concerns and collaboratively develop solutions or elevate concerns to executive leaders.

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. In an interview, facility leaders highlighted an increase in veterans enrolled to receive care at the facility from 122,152 in FY 2023 to 140,431 in FY 2024.

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

[70] VHA Handbook 1101.10(2).

[71] "The Pathway to Excellence Program - the premier designation for healthy work environments - recognizes health care organizations that demonstrate a commitment to establishing the foundation of a healthy workplace for staff." "About Pathway," American Nurses Credentialing Center, accessed February 18, 2025, https://www.nursingworld.org/pathway. The facility received designation status in 2019 and redesignation in 2023.

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.[72]

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).[73] 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."[74]

The OIG found the program exceeded the HCHV5 target in FYs 2023 and 2024. The HCHV Program Coordinator attributed the scores to consistent staffing and successful efforts to identify veterans and complete assessments. To identify veterans, program staff participate in the annual point-in-time count, receive self and community referrals, and meet with community partners to review lists of homeless veterans. In an OIG questionnaire, the coordinator stated that four homeless outreach social workers identify homeless veterans in streets, encampments, shelters, and rural communities to enroll them in the program.

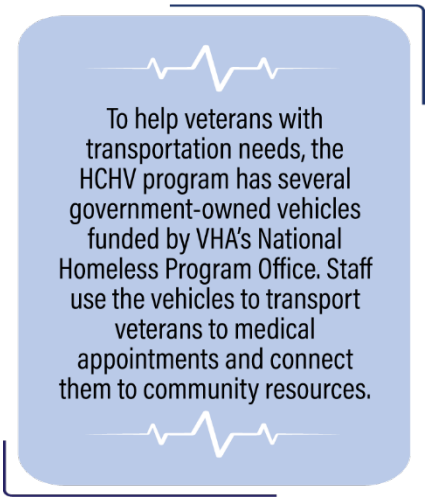

Figure 14. *Veterans' transportation needs.*
Source: OIG interview with program staff.

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

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

[74] 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.

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).[75]

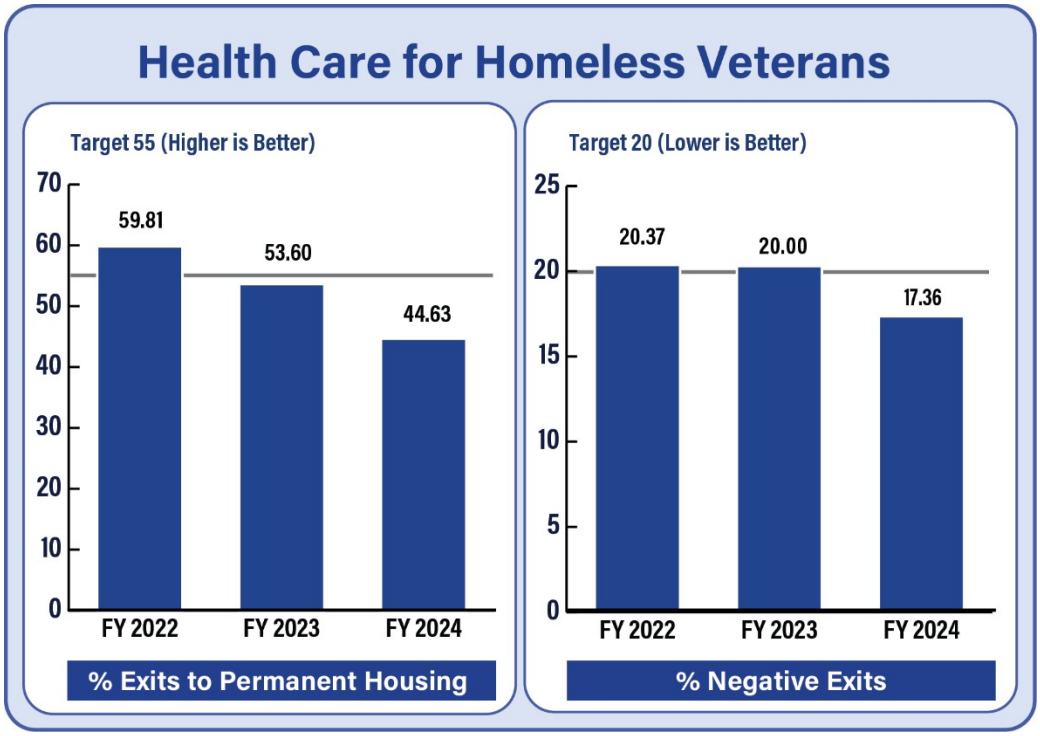

Figure 15. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

While the facility met the HCHV1 target in FY 2022, it did not meet targets in FYs 2023 or 2024. VHA captures data for this metric by counting veterans discharged from Contract Emergency Residential Services and Low-Demand Safe Haven programs to permanent housing.[76] HCHV staff clarified that their contracted facility offers transitional housing for

[75] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[76] "Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing." "Low Demand Safe Havens (LDSH) are 24-hour staffed transitional residences with private or semi-private accommodations that target the population of hard-to-reach, chronically homeless Veterans with mental illness, many with SUD [substance use disorder] and when traditional residential treatment programs do not meet a Veteran's needs." VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025. The HCHV1 and HCHV2 performance measures include veterans discharged from contracted residential housing services or low-demand safe haven programs.

35 male and 6 female veterans, with a limited 90-day length of stay. The HCHV Program Coordinator stated the 90-day limit poses a significant barrier to meeting the target, especially for veterans with complex mental health issues who are not ready to transition to permanent housing. Staff, instead, transferred them to other transitional facilities that do not count in the metric.

The facility met the HCHV2 target for FYs 2023 and 2024. Program staff said they collaborated with residential services staff to keep veterans enrolled in the program by addressing mental health and behavior modification needs to decrease the likelihood of negative exits. Program staff also shared they worked with contract residential staff to develop a policy defining resident rule violations, and verbal warning and discipline processes. The goal was to ensure reasonable opportunities for veterans to improve their behavior prior to being discharged from the program. The policy also reinforces an individualized approach to support veterans, such as requiring contract residential case management staff to evaluate veterans for treatment options when they exhibit behavior related to substance use disorder.

Furthermore, staff explained they collaborate with community partners to connect veterans to financial assistance, food resources, medical and dental services, homeless shelters, and VA services. The coordinator described a strong relationship with community partners in San Antonio, which had homeless outreach workers assigned to every district. In addition, program staff said they collaborate with the facility's Homeless Patient Aligned Care Team to help address veterans' medical needs.[77]

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."[78] 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.[79]

[77] "HPACT [Homeless Patient Aligned Care Team] is an innovative treatment model that VAMCs [VA medical centers] across the country are implementing to provide a coordinated 'medical home' specifically tailored to the needs of Veterans experiencing homelessness." VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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

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

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).[80] The program did not meet the target for FYs 2022 through 2024. The program coordinator said they did not meet it because of staffing challenges.

The coordinator explained the program had eight vacant case management positions in FY 2022. Despite adequate program staffing in FYs 2023 and 2024, the coordinator added that the largest public housing authority in the area also experienced severe staffing challenges, which delayed voucher application processing and permanent housing placement. In response, program staff, VISN leaders, and the local housing authorities developed action plans to streamline processes to determine eligibility and administer vouchers timely. Because of these efforts, the program met the performance measure target by January 2025.

Staff described the San Antonio Coalition for Veterans and Families as a community partner that offers unique services to assist with urgent needs of veterans and families. Notably, when a single parent's car was towed while unloading their children and groceries in front of their voucher housing, coalition staff helped the veteran retrieve it and covered repair costs.

Figure 16. *The San Antonio Coalition for Veterans and Families. Source: OIG interview.*

Program staff told the OIG they collaborated with four public housing authorities on a total of 837 allocated vouchers to help house veterans. Program staff described having adequate staffing that consisted of 26 individuals, which included social workers, a substance use disorder specialist, a nurse, and a licensed chemical dependency counselor.

During an interview, the program coordinator shared that staff enroll veterans into the program through self and community referrals and outreach events. Program staff said they participated in community outreach activities such as the Homeless Stand Down event, a work group with community partners, monthly meetings with Supportive Services for Veteran Families, and the annual homeless point-in-time count.[81]

[80] 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*.

[81] "Stand downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3 -day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022. Supportive Services for Veteran Families provides case management and support to prevent homelessness, "or to rapidly re-house veterans and their families." "Supportive Services for Veteran Families," Department of Veterans Affairs, accessed February 12, 2025, https://www.va.gov/homeless.

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).[82] The program met the target for FYs 2022 and 2023 but fell short by 1 percent in FY 2024. The program coordinator described being adequately staffed with an employment coordinator and three employment specialists, and said the facility has a Compensated Work Therapy program to help veterans find employment.[83]

Program staff reported changing demographics of veterans in the program, with participants being older but still wanting to work. However, advanced age and health related issues have made it more difficult for some veterans to find and sustain employment. Staff explained that community partners provided financial support for security deposits and utility bills, distributed groceries at food banks, and assisted with VA benefit applications.

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]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[86] The program exceeded the target for FYs 2023 and 2024. Program staff said to meet the target they conducted outreach at jails and prisons, participated in local police department meetings, and attended community resource fairs.

In an OIG questionnaire, staff stated they identified and enrolled veterans, and developed relationships with them through face-to-face communication, video conferencing, phone calls,

[82] 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*.

[83] The Compensated Work Therapy program "provides time-limited transitional housing with supported employment services to homeless Veterans with mental health and substance use disorders, co-occurring medical concerns and psychosocial needs including homelessness and unemployment." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

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

[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*.

and letters. In addition to using the Veterans Re-entry Search Service, the Bexar County jail provided a self-service kiosk that allowed incarcerated individuals to voluntarily declare their status as veterans.[87]

Program staff described how they built strong community relationships with law enforcement agencies and crisis intervention teams. Staff educated local law enforcement on VA medical, mental health, military sexual trauma, and interpersonal violence (the use of physical, sexual, or psychological power against another person or group) services. In addition, HCHV and Veterans Justice Program staff met quarterly to collaborate to identify community resources. During a recent quarterly meeting, staff of both programs toured a tiny home community that offered low-income housing to people 55 years or older with a one-year history of homelessness. Program staff described plans to help veterans get on the community's wait list.

Meeting Veteran Needs

In an interview, program staff said they participated in four veterans treatment courts and visited veterans in 22 jails and 19 prisons in 30 counties.[88] The staff said they conducted presentations and provided information to jail staff and incarcerated veterans about how to contact the program for assistance. They also distributed information through postcards and physical and digital posters.

During the interview, program staff also explained that veterans treatment court judges' requests for treatment varied.[89] Program staff reported one particularly challenging treatment court case when the judge's requests were beyond the scope of the facility's services and breached patient privacy. To overcome this challenge, the program coordinator implemented a new formal agreement between the program and treatment courts to clearly establish boundaries for judges' requests. It also required judges to submit all requests for treatment and medical records in writing rather than through verbal requests, which was the previous practice. This clear, well-

[87] The Veterans Re-Entry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military." "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) - Terms and Conditions of Use," Department of Veterans Affairs, accessed January 30, 2025, https://vrss.va.gov. (This website is not publicly accessible.)

[88] 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.

[89] "Unlike traditional criminal courts, the primary purpose of a VTC [Veterans Treatment Court] is not to determine whether a defendant is guilty of an offense, but rather to ensure that he or she receives treatment to address unmet clinical needs." Department of Veterans Affairs, "Veterans Treatment Courts and Other Veteran-focused Courts Served by VA Veterans Justice Outreach Specialists" (fact sheet), March 2025.

documented communication and formal agreement reduced misunderstandings and built trust between judges and program staff.

Program staff shared a success story involving an incarcerated veteran with severe mental illness who needed inpatient psychiatry treatment. Staff described limited availability and lengthy wait times at outside facilities and said it could take up to six months for veterans to access appropriate treatment. A program staff member recognized the critical need for timely care and intervened to collaborate with the facility's inpatient mental health staff and facilitate the necessary assessments for the veteran.

Through these efforts, staff helped to admit the veteran to a community facility approximately three months sooner than would have been possible through the standard referral process. This intervention not only provided the veteran with mental health treatment but also demonstrated the importance of collaboration between correctional facilities and VHA services to support veterans' health and well-being. As a result of successful treatment, the veteran was discharged to transitional housing and subsequently acquired permanent housing with a Housing and Urban Development–Veterans Affairs Supportive Housing voucher.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to cleanliness and test result communication. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Responses). 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.

OIG Recommendations and VA Responses

Recommendation 1

The Associate Director for Operations ensures staff keep patient care areas clean and clean storage areas free of dirty items and equipment.

_X_ Concur

____ Nonconcur

Target date for completion: March 1, 2026

Director Comments

The Associate Director for Operations, Environmental Management Services (EMS) and Nursing leadership reviewed the facility's current process for maintaining a clean environment. Nurse managers or designees will perform weekly inspections of clean storage areas to ensure no comingling of clean/dirty items. Numerator will be the number of inspections with no comingled items; Denominator is the total number of inspections completed. Quality Management will monitor until 100% compliance is maintained for six consecutive months.

Nurse manager or designee will perform weekly inspections of refrigerator seals to ensure cleanliness. Numerator is the number of inspections in which rubber seals were found to be clean; Denominator is the total number of inspections completed. Quality Management will monitor until 100% compliance is maintained for six consecutive months.

Chief of EMS or designee will perform weekly inspections of floors to ensure cleanliness. Numerator is the number of inspections in which cleaning log was current and floors were found to be clean; Denominator is the total number of inspections completed. Quality Management will monitor until 100% compliance is maintained for six consecutive months.

Recommendation 2

The Chief of Staff ensures the facility has workflows for all services to identify team members' roles in the test result communication process.

_X_ Concur

____ Nonconcur

Target date for completion: March 1, 2026

Director Comments

The Chief of Staff and Chief of Quality Management reviewed VHA Directive 1088(1) Communicating Test Results to Providers and Patients, dated July 11, 2023, and amended

September 20, 2024, as well as Medical Center Policy 11-22-78, Communicating Test Results to Providers and Patients, dated April 11, 2022. It was identified that the current policy did not include workflows for all services with identification of team members' roles in the test communication process. Chief of Staff and Quality Management are in the process of developing service level workflows to align with VHA Directive 1088(1).

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 six VSOs; however, none of the VSOs responded. 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 January 13 through 16, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

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

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection*

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.*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 29, 2025

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

Subj: Healthcare Facility Inspection of the South Texas Veterans Health Care System in San Antonio

To: Director, Office of Healthcare Inspections (54HF01)

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

1. Thank you for the opportunity to review the draft report. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. We note that the OIG made recommendations and appreciate the OIG's comprehensive review.
2. I concur with the findings and recommendations and will work with South Texas Veterans Health Care System leadership to ensure actions are taken to correct these findings described in the draft report.
3. Should you need further information, please contact the Veterans Integrated Services Network Quality Management Officer.

(Original signed by:)

Wendell Jones, M.D., M.B.A
VISN 17 Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 29, 2025

From: Director, South Texas Veterans Health Care System (671)

Subj: Healthcare Facility Inspection of the South Texas Veterans Health Care System in San Antonio

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

1. Thank you for the opportunity to review and respond to the recommendations in the draft report regarding the healthcare inspection report at South Texas Veterans Health Care System in San Antonio, TX. South Texas Veterans Health Care System is committed to continuous improvement to deliver exceptional healthcare to Veterans.
2. I concur with the findings and recommendations and will ensure actions are taken to correct these findings described in the draft report.

(Original signed by:)

Julianne Flynn, MD

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Miquita Hill-McCree, MSN, RN, Director Mark Bartuska, MHA, RN, Team Leader Edna Davis, BSN, RN Elisa Gomez, MSN, RN Simonette Reyes, BSN, RN
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

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US House of Representatives: Greg Casar, Joaquin Castro, Michael Cloud, Henry Cuellar, Monica De La Cruz, Tony Gonzales, August Pfluger, Chip Roy

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