US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA El Paso Healthcare System in Texas

Healthcare Facility Inspection	25-00193-155	July 16, 2026

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

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA El Paso Healthcare System (the facility) from January 14 through 16, 2025. The facility is rated as *2-medium complexity* and in fiscal year 2025, provided direct care to about 43,000 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2] The OIG also requested updates from facility leaders about actions they took since the inspection to address the team's findings.

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team observed general uncleanliness in various areas and made one related recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Primary Care.** The OIG assessed whether primary care teams were staffed according to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[3] The OIG determined that in January 2026, healthcare providers had not completed 449 secondary (follow-up) screens for toxic exposure that were older than 30 days. This problem was identified previously in December 2024, when staff reported to the OIG that the facility had 677 incomplete secondary toxic

[1] VHA classifies facilities based on their complexity level. A 2-medium complexity facility has "medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, "Facility Trip Pack (VISN [Veterans Integrated Service Network] 17) El Paso Clinic," last updated November 26, 2025.

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

[3] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026; VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

exposure screens older than 30 days. VA's *Toxic Exposure Screening Process* guide sets the standard for staff to complete the secondary screening within 30 days.[4] The OIG made one related recommendation.

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

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

What the OIG Recommended

1. Executive leaders ensure staff maintain a clean and safe environment.
2. The Medical Center Director ensures providers complete secondary toxic exposure screenings within 30 days.

VA Comments and OIG Response

The Deputy Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C). The OIG will follow up on the planned actions until they are completed.

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[4] VA, *Toxic Exposure Screening Process*, updated January 2025.

Abbreviations

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

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[6]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[7]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[8]

Primary Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.[9]

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

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

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

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

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

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

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

The VA El Paso Healthcare System (the facility) consists of the El Paso VA Clinic, four outpatient clinics in New Mexico and Texas, the South-Central Wellness Center for outpatient mental health, and an off-site sleep center. The facility also works with the William Beaumont Army Medical Center, which offers emergency services. In fiscal year (FY) 2025, the facility provided care to about 43,000 unique patients, with an operating budget of about $724 million.[11] In December 2023, the facility received funding for a new healthcare center, scheduled to open around 2029.

Figure 1. *Facility photo.*
Source: VA, VHA Facility Trip Pack, (VISN 17) El Paso VA Clinic, updated August 16, 2024.

The OIG team inspected the facility from January 14 through 16, 2025. The executive leaders referred to throughout this report include the Acting Executive Director (Director), Associate Director, Chief of Staff, Assistant Director, and Associate Director for Patient Care Services. The facility liaison reported that the Acting Director was appointed in 2024, the Associate Director and Chief of Staff in 2021, the Assistant Director in 2023, and the Associate Director for Patient Care Services in 2020.

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[12] The OIG administered its own facility-wide questionnaire, interviewed executive and facility leaders and employees, and considered data from patient advocates.[13]

System Shocks

In an interview, executive leaders described two veteran suicides in 2023 and 2024 and limited clinical space as system shocks. Leaders reported that employees were distraught by the suicides

[11] VA, "Facility Trip Pack (VISN [Veterans Integrated Service Network] 17) El Paso Clinic," last updated November 26, 2025.

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

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

and by negative reports in the media. In the immediate aftermath, leaders offered crisis debriefings and ensured chaplains and mental health professionals were available to employees. They also worked to dispel misinformation circulated by the media to maintain truth and transparency. In addition, the leaders tasked the behavioral health team to reeducate employees on crisis protocols, which included a review of actions they should take if they encounter a veteran in crisis. By January 2025, the facility was still actively applying lessons learned from both incidents. As to the lack of clinical space, executive leaders reported this was due to growth in the veteran population given the attraction of good weather in the area and military retirees staying in the community. Leaders said construction on a new healthcare center began in August 2024 with more clinical space, which will be approximately 490,000 square feet and co-located with the William Beaumont Army Medical Center. The new facility is scheduled to open in August 2029.

Employee Experiences

Most OIG questionnaire respondents indicated they feel comfortable reporting safety concerns and nearly half were comfortable suggesting ways to improve their work environment. Executive leaders said they send a monthly newsletter with upcoming events and job opportunities, walk through the facility to meet with employees, and the Director meets with employees every Monday during lunch. They also support positive employee engagement through monthly walking challenges, displays of employees' paintings throughout the facility, and a meditation room available for employees to use.

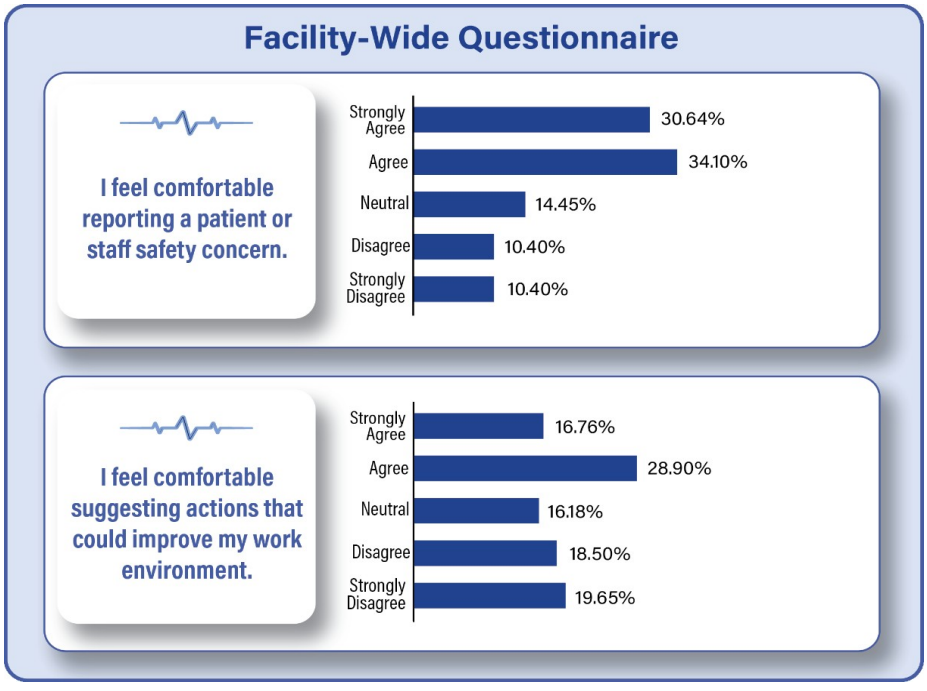

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

Executive leaders said they hold monthly virtual town halls to address veterans' concerns, attended by veterans and facility leaders. Further, executive leaders described positive partnerships with government leaders, as well as veterans service organizations and community faith leaders. Employees use these partnerships to share information about available resources and support services to help veterans.

The acting lead patient advocate reported serving as a liaison between advocates and facility leaders, as well as collaborating with service chiefs and executive leaders to resolve veterans' concerns. The advocate escalated issues to the Director when necessary.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[14] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[15]

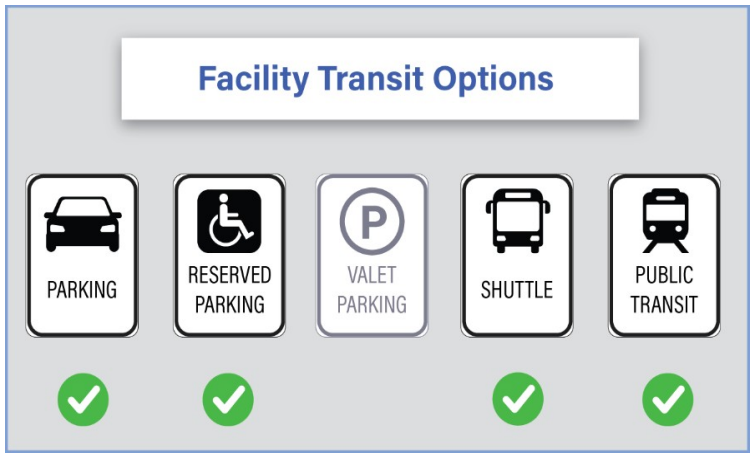

Figure 3. *Transit options for arriving at the facility.*
Source: OIG observations and interviews with facility staff.

General Inspection

The OIG team used the address on the facility's public website to get directions and easily found the main entrance. Interviews with staff and team observations confirmed there was a shuttle and public transportation to the facility. Also, a parking lot and

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

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

garage were adjacent to the main entrance with an elevator and ramp that offered ample parking, including reserved spots for wheelchair accessibility. However, several light bulbs needed replacement, and the emergency contact information posted on signs in the parking garage was inaccurate. The Joint Commission, *Standards Manual*, EC [Environment of Care] standard 02.01.01 requires hospital staff to minimize safety and security risks in the physical environment.[16] Sufficient lighting and accurate emergency contact information on signs are essential to ensure veterans can navigate parking garages and request help when needed. The deputy chief of engineering submitted follow-up photos in December 2025 that showed adequate lighting in the parking garage and signs that had been updated with an emergency phone number. Therefore, the OIG did not make a recommendation.

The main entrance was well-lit and spacious, and the information desk had printed maps of the facility. In addition, there were assistive devices, such as wheelchairs, available for veterans to use, along with a coffee bar and popcorn stand.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG observations.

The facility had directional signs on walls, maps in elevator corridors, and a wayfinding kiosk near the front desk that provided directions to help veterans navigate. There were also braille signs and audio announcements in the elevators to assist veterans with visual impairments. Information desk staff stated they are unable to communicate in sign language, but they write notes and have a directory of staff available to assist veterans with hearing impairments when needed.

However, the OIG found general uncleanliness throughout the facility. A men's restroom had paper and debris on the floor, clogged toilets, and water overflowing on the floor in one stall. There was also dust and debris on equipment and exam tables, behind chairs, and on the floor. When the medical facility is not cleaned regularly, bacteria or viruses can accumulate and increase the risk of infection for veterans and employees who use those spaces. Follow-up information provided by the infection control and prevention program coordinator in December 2025 included policies and procedures related to workplace cleanliness but did not address how leaders would maintain a clean facility—prompting the OIG to make the following recommendation.

[16] The Joint Commission, *Standards Manual*, E-dition, EC.02.01.01, January 1, 2025.

Recommendation 1

Executive leaders ensure staff maintain a clean and safe environment.

__X__ Concur

____ Nonconcur

Target date for completion: January 29, 2027

Director Comments

Environmental Management Services (EMS) staff inspect and clean all areas within the healthcare facility, at least daily. The daily cleaning of restrooms is documented on a "Restroom Cleaning Log" located on the back of the door, visible when exiting each restroom, thus allowing the public to see when the restroom was last cleaned. All public restrooms also have signage posted on the wall stating the phone number to contact if the restroom does not meet the standards of the user. An EMS Technician (EMS Tech) has been assigned to regularly inspect high-traffic restrooms in public areas during each business day to continuously maintain cleanliness. Twenty-four standard operating procedures (SOP), to include dusting, exam room and restroom cleaning/disinfection, have been implemented to guide and maintain the routine cleaning/disinfection of the facility by EMS staff. EMS staff training on the updated procedures and expectations was completed on June 2, 2026. Oversight of cleanliness throughout the facility is conducted on a daily basis by the Chief of EMS. In addition, the Associate Director conducts weekly inspections of cleanliness during Environment of Care (EOC) rounds. All employees throughout the healthcare system were informed of their role in maintaining a clean, safe, and healthy environment for our Veteran patients during an all-employee town hall held on June 2, 2026.

Facility's Actions Responsive to OIG Inspection

Additionally, the OIG found the primary care and women's health clinics had multiple clean pieces of equipment and supplies stored in the soiled utility room. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* requires staff to store clean and soiled items separately to prevent infections.[17] The nurse manager was unable to explain why staff stored the items together. The Associate Director was unaware of the issue and said the OIG's findings highlighted new areas to focus on during routine inspections. An executive leader submitted information in December 2025 that confirmed separate rooms

[17] VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.

were designated to store soiled and clean items. Staff also reported they are inspecting these areas monthly to verify appropriate storage. Therefore, the OIG did not make a recommendation.

The primary care clinic had expired respiratory masks in a clean storage room. The nurse manager reported that nursing staff posted a note with instructions not to use the masks because the manufacturer's expiration date had passed. However, the supply chain chief said guidance to clinic staff is to discard the expired supplies or return them. The comprehensive environment of care committee coordinator said members were unaware of the expired items because they have not inspected the storage room in six months. Staff said this was due to the room being locked during environment of care rounds. A committee member noted that a supervisor for the area can unlock the door if they are participating in the inspection rounds. The OIG did not make a recommendation because the supervisory safety manager reported in December 2025 that members of the environment of care team now have access to all spaces, including restricted areas.

Staff discussed an ongoing issue with an emergency alert system at an outpatient clinic. The system enables staff, patients, and visitors to send an alert when they require help. Staff expressed concern that after someone pulls the alarm, the system cannot be reactivated until it is reset. The chief of police explained that because the reset button is in the police station, a police officer must be present to grant access to staff. The deputy chief of engineering submitted information in December 2025 that verified staff had relocated the emergency alert system from the locked police station to a corridor accessible to nursing staff, and therefore, the OIG did not make a recommendation.

Finally, there was a damaged concrete floor in a women's restroom. The damage created an uneven surface, which increases fall risks, especially for those who use assistive walking devices. The OIG found similar findings of floor damage in the annual workplace evaluation conducted by the Veterans Integrated Service Network (VISN) in FY 2024.[18] The comprehensive environment of care coordinator was unable to provide a rationale for the problem. In December 2025, the deputy chief of engineering submitted photos of the women's bathroom floor that showed the damaged floor had been repaired. The deputy said staff will inspect the areas annually and enter a work order if they identify damage. Therefore, the OIG did not make a recommendation.

[18] Veterans Integrated Service Networks (VISNs) are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Networks," VA, accessed November 14, 2025, https://www.va.gov/visns.

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

Communication of Urgent but Noncritical Test Results

The OIG determined the facility had standard operating procedures and workflows that outline the communication process, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[19] Leaders also reported monitoring providers' compliance with timely communication of urgent, noncritical test results to patients. The OIG reviewed the facility's related external measure data and noted the scores showed consistent improvement from quarter three of FY 2024 to quarter one of FY 2025.

Action Plans and Process Improvements

The OIG reviewed prior OIG reports and a 2024 Joint Commission survey and noted all recommendations were closed. Quality management staff said they examine patient safety events, patients' feedback, and external review data to identify recurring themes for opportunities for improvement. They also review patient safety data at service-level meetings, which allows them to immediately identify issues that may require further examination.

The OIG team assessed whether primary care teams were staffed in compliance with VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care* and Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[20] The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data and new patient appointment wait times.

[19] El Paso VA Healthcare System Standard Operating Procedure 11-130, "Communication and Management of Test Results," November 15, 2024; VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[20] VHA Directive 1406(3); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

Primary Care Teams

The facility offers primary care services at the El Paso VA Clinic and outpatient clinics in the surrounding area. A primary care leader discussed using education loan repayments, retention incentives such as higher pay rates for physicians, and alternate work schedules to recruit and retain staff.

A primary care staff member said patients are scheduled for an initial appointment when they enroll for care at the facility. Executive leaders said they added primary care teams and providers who can fill in where needed to ensure all patients have access to care when a provider is on leave or has left the facility. They also offer virtual appointments, which allow providers to see patients despite limited clinical space.

Primary care leaders shared a process improvement project they completed that addressed the amount of time providers spent documenting care in the electronic health record. Leaders simplified the note template providers used during visits, which reduced the average documentation time from eight to five minutes per patient. Since each provider sees about 11 patients daily, leaders said the project saved each provider an average of 30 minutes a day.

Although wait times for established patients were less than a week, at the time of the inspection in January 2025, primary care leaders said some patients indicated on a survey they had waited more than 30 days for an appointment when they felt they needed care immediately. To address this concern, leaders initiated a project to educate patients about the availability of same-day, walk-in (nonscheduled) appointments in primary care clinics instead of the emergency department. Leaders shared this information at town halls and have instructed emergency department providers to redirect patients seeking nonemergency care to walk-in appointments.

Toxic Exposure Screening Navigators

VA medical facilities have toxic exposure screening navigators to meet the requirements of the Sergent First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, which expanded health care for veterans who were subjected to toxic substances during their military service.[21] According to the *Toxic Exposure Screening Installation and Identification of Facility Navigators* memorandum, each facility should identify two toxic exposure screening navigators.[22] In interviews with primary care staff, the OIG learned that clinical staff or the facility's two toxic exposure screening navigators complete initial

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

[22] 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; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

screenings. Providers complete a secondary (follow-up) screen if veterans report a toxic exposure or indicate they are unsure of their exposure during the initial screen.

In December 2024, in response to an OIG request, facility staff provided a document showing the facility had 803 incomplete secondary screens, with 677 that were older than 30 days. VA's *Toxic Exposure Screening Process* guide sets the expectation for staff to complete the secondary screening within 30 days.[23] At the time of the OIG visit in mid-January 2025, the facility had 467 open secondary screens. Leaders attributed the improvement to sending emails every other day to the responsible providers and assigning a dedicated provider to monitor the screening process. Nearly a year later, on January 5, 2026, the OIG followed up and reviewed the facility's Toxic Exposure Screening Dashboard and found that providers had not completed 449 secondary screens. When providers do not complete screens within 30 days, patients may experience a delay in follow-up care.

Recommendation 2

The Medical Center Director ensures providers complete secondary toxic exposure screenings within 30 days.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2026

Director Comments

There are currently zero unresolved secondary Toxic Exposure Screenings (TES) over thirty (greater than 30) days according to the "Power BI VSSC PACT Act Toxic Exposure Screens" (Power BI TES) dashboard for the El Paso VA Healthcare System. A Standardized Operating Procedure (SOP) to formalize a process for providers to review secondary TES in a timely manner before 30 days is under development. Implementing this SOP will transition the facility's current informal process to a structured workflow. The Clinical Executive Council (CEC), chaired by the Chief of Staff, will provide oversight of toxic exposure screening for the organization. TES Secondary Screening data, including unresolved TES greater than 30 days, will be reported monthly to the CEC. This reporting started on June 1, 2026. Per the June 2026 CEC report, the number of secondary screenings due currently were 12 and the number of secondary screenings greater than 30 days were zero as of June 1, 2026. The goal is to maintain zero unresolved secondary TES greater than 30 days for six consecutive months to demonstrate ongoing compliance.

[23] VA, *Toxic Exposure Screening Process*, updated January 2025.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[24]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[25] However, this fiscal year (FY 2026), VHA no longer uses this intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[26] Finally, HCHV2 measured the percentage of veterans who were discharged from program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[27] At the time of the OIG inspection in January 2025, FY 2024 was the most current data available for these performance measures.

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

[25] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

[26] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[27] VHA also sets the target for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures.*

Performance and Improvement Highlights

- The facility's HCHV program did not meet the intake percentage (HCHV5) target for FY 2024. The associate chief of staff for behavioral health services said vacant positions negatively affected outreach, which led to staff completing fewer intake assessments. HCHV staff said two new outreach staff started in November and December 2024, and an acting HCHV program manager was assigned two months before the OIG's inspection in January 2025 (and hired permanently in September 2025).
- The program met the permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2024. HCHV staff told the OIG they support veterans through a combination of outreach and referrals to shelters, hospitals, and community partner services.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[28] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[29]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3) and the percentage of veterans employed (performance measure VASH3).[30]

Performance and Improvement Highlights

- The facility's program met the voucher use (HMLS3) target in FY 2024. Staff credited collaboration with housing agencies for increased voucher use.
- Program staff attributed their success in meeting the employment (VASH3) target in FY 2024 to the beginning of the process, when staff refer veterans to an

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

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

[30] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

employment specialist who provides them with available options such as compensated work therapy.[31]

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[32] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[33]

Performance and Improvement Highlights

- The facility did not meet the program enrollment (VJP1) target in FY 2024. Facility program staff reported outreach efforts slowed when a staff member took extended leave and remaining staff focused on supporting veterans in treatment courts, which decreased enrollment in the program.[34]
- Staff shared a success story of a veteran who reconciled with their estranged family, completed program requirements, and became a mentor at a veterans treatment court.

[31] Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, last updated October 13, 2021, https://www.va.gov/health/cwt.

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

[33] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

[34] A veterans treatment court is a "long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the El Paso facility, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the facility's environment of care and toxic exposure screenings. 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.

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

Appendix A: Methodology

The OIG inspection team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[35] The OIG administered a voluntary questionnaire to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The team'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*.[36]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[37] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The team inspected the facility from January 14 through 16, 2025. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[38] The OIG reviews available evidence within a

[35] The accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

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

[37] 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.

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

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 8, 2026

From: VISN/HAS Director, VA Heart of Texas Health Care Network (10N17)

Subj: Healthcare Facility Inspection of the VA El Paso Healthcare System in Texas

To: Director, Office of Healthcare Inspections (54HF05)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review and provide a response to the OIG Healthcare Facility Inspection of the VA El Paso Healthcare System in Texas draft report.
2. I have reviewed the document and concur with the findings, recommendations, and submitted action plans listed. Corrective actions have been implemented based upon the recommendations provided.

(Original signed by:)

Jamie Park, Ed.D.
Deputy Network Director, VISN 17/HSA-41

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 3, 2026

From: Director, VA El Paso Healthcare System (756)

Subj: Healthcare Facility Inspection of the VA El Paso Healthcare System in Texas

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

1. Thank you for the opportunity to review and provide a response to the OIG Healthcare Facility Inspection of the VA El Paso Healthcare System in Texas draft report.
2. I have reviewed the document and concur with the recommendations listed. Corrective actions have been implemented based upon the recommendations provided.

(Original signed by:)

Mark Rielo, Executive Director
El Paso VA Health Care System

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