US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Houston Healthcare System in Texas

Healthcare Facility Inspection	26-00029-236	August 13, 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 Houston Healthcare System (the facility) from December 15 through 18, 2025. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to over 134,000 veterans.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal issues that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **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.

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated March 23, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible.)

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

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C). No further action is required.

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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.[4] 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.[5]

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.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[8]

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[4] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[5] 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.

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

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

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

The VA Houston Healthcare System (the facility) serves veterans across southeast Texas. It includes a medical center in Houston and 11 community-based outpatient clinics in Beaumont, Conroe, Galveston, Humble, Katy, Lake Jackson, Lufkin, Richmond, Sugar Land, Texas City, and Tomball. In fiscal year (FY) 2025, the facility's medical care budget was over $2.2 billion. It had 389 inpatient hospital, 48 domiciliary, and 141 community living center beds, and served over 134,000 veterans.[9]

Figure 1. *Facility photo. Source: "VA Houston Health Care," VA, accessed April 7, 2026, https://www.va.gov/houston-health-care.*

The OIG inspected the facility from December 15 through 18, 2025. The executive leaders referred to throughout this report include the acting Medical Center Director (acting Director), acting Associate Director/Deputy Medical Center Director (acting Deputy Director), Chief of Staff, and Associate Director for Patient Care Services.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[10] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[11] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[12]

[9] "Locations," VA, accessed January 22, 2026, https://www.va.gov/houston-health-care/locations; A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated June 3, 2025, https://www.va.gov/CLC. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, last updated March 23, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible.)

[10] 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.

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

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

System Shocks

During the December 2025 interviews, executive leaders identified leadership transitions and administrative and clinical position vacancies as system shocks. The acting Director said the former Director retired in February 2025, and the previous Associate Director for Patient Care Services was removed at the end of 2024. Because both leaders held their positions for many years, the departures created uncertainty among employees. In response, the new Associate Director for Patient Care Services focused on engaging employees, increasing communication, and addressing nursing needs, which led to positive feedback from employees. The executive leaders described working as a team to build trust with employees through increased two-way communication during the transitions.

Leaders also discussed the effects of the January 2025 executive orders and memorandums, such as the hiring freeze (in effect from January 20, 2025, to October 15, 2025) and return-to-work mandate, on services and patient care.[13] The acting Director said the facility lost several radiologists and there were multiple vacancies for providers and medical support assistants. The acting Deputy Director explained that the veteran population in the area is growing, and leaders want to increase services.

The leaders also described challenges expanding patient care services without administrative and support employees, who were not exempt from the hiring freeze. Leaders used contract workers in some cases. Because of supply chain vacancies at that time, nurses and other clinical employees helped deliver supplies to ensure patient care was not affected.

Employee Experiences

Executive leaders described multiple methods they use to engage employees and receive feedback, including monthly town halls, visits to work areas to meet with employees, weekly newsletters to share information and patient compliments, and tiered huddles (brief meetings that include leaders and frontline employees). The acting Deputy Director described actively collaborating with service leaders during daily morning meetings and addressing any concerns raised. Additionally, employees report concerns to executive and service leaders through emails and the Joint Patient Safety Reporting system—a database for employees to document patient

[13] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

safety events.[14] The Chief of Staff and Associate Director for Patient Care Services also described regular meetings with supervisors and employees to gather improvement suggestions. The acting Deputy Director expressed confidence that employees are comfortable raising concerns to leaders. Because of a transmission error with the written OIG questionnaire, corroborating information was unavailable, and the team relied on interviews with personnel.

To gain additional feedback to guide communications and improvement efforts, leaders developed and distributed an All Employee Check-In Survey in late 2025. The survey explored employee experiences with workload, communications, interactions with supervisors, safety concerns, and job satisfaction. Leaders were awaiting final survey data.

Veteran Experiences

The OIG team found the facility's VSignals scores were consistently high, but they did not meet VHA's national average for most of FY 2025 (see figure 2). Patient advocate respondents to an OIG questionnaire reported the most common complaints from veterans involve difficulties scheduling appointments and changing to a new provider. In an interview, leaders acknowledged these challenges. The acting Deputy Director explained that medical support assistant vacancies negatively affected scheduling timeliness, although they were actively recruiting to fill the positions. The Chief of Staff described starting a new initiative at the end of 2025 that brings in a supervisor to help find a resolution when a provider and veteran disagree on recommended treatment to help minimize the need for provider changes.

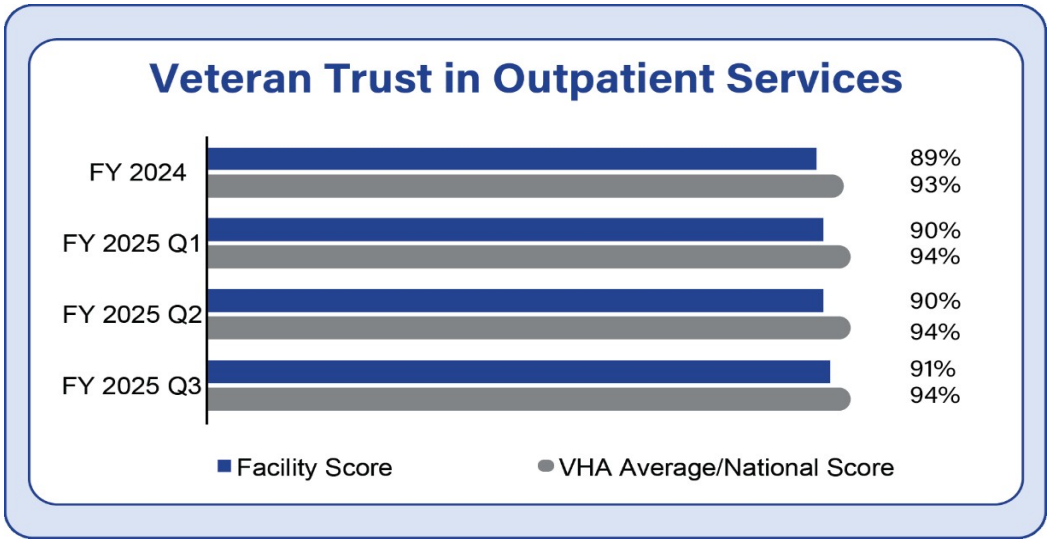

Figure 2. *Veteran trust in outpatient services.*
Source: VSignals data.

[14] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 6.0*, October 2025.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[15] 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.[16]

General Inspection

Documents and OIG team observations confirmed ample parking, including accessible spaces for those with mobility issues. Parking lots were equipped with security cameras and patrolled by police. There were also multiple transit options as shown in figure 3.

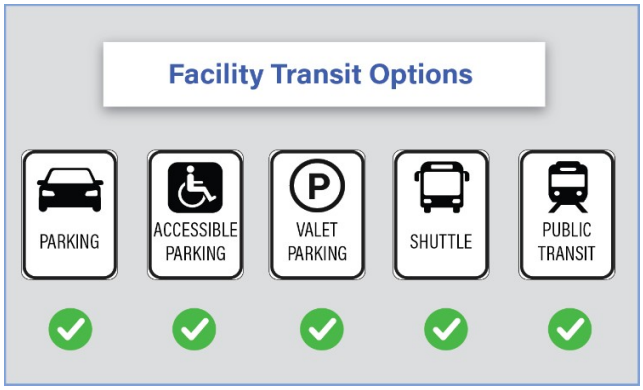

Figure 3. *Transit options for arriving at the facility. Source: Facility maps, OIG team observations, and facility liaison questionnaire responses.*

Inspectors observed directional signs at the facility's entrance and throughout the campus, and directories listing clinic and office locations in corridors and on walls throughout the facility. In the lobby, employees at the information desk provide directions and handheld maps, and escort veterans to appointments as needed. Based on the facility liaison's response to an OIG questionnaire and supporting documents, the OIG learned the facility offers tools and resources for sensory-impaired veterans, including assistive listening devices, braille on signs, and large-print font materials.

The team inspected patient care areas and the community living center and found them clean and well lit. Medical equipment had current inspection stickers, and staff protected patient privacy.

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

[16] 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.

Personal protective equipment, such as gloves and masks, was readily available, and contaminated medical waste was stored in a locked area with restricted access.

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 policies and processes to communicate abnormal test results to providers and patients, to assign a surrogate (substitute) when a provider is unavailable, and to communicate results outside regular clinic hours. The Chief of Staff and quality management employees explained that each service uses a portal to ensure a surrogate is assigned in the patients' electronic health record system to communicate test results.

In mid-2024, leaders implemented software that allows providers to send automated test result letters to patients. They also implemented a program for employees to access and update providers' on-call schedules and their contact information. The Chief of Staff and quality management employees said this program ensures employees have current and accurate coverage information. Further, a supervising provider receives all diagnostic test results ordered by physicians in training. The OIG team found these process improvements strengthened test result communication timeliness, reduced administrative burdens, and enhanced patient safety.

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires providers to communicate test results that require action to patients within seven days after the results become available.[17] The Chief of Staff and quality management employees said they monitor providers' compliance with this standard through VHA's External Peer Review Program.[18] The OIG team noted improvement in the facility's data in FY 2025, with an increase in compliance from 63 percent in the first quarter to 86 percent in the fourth quarter. Quality management employees also said they randomly audit approximately 50 patient electronic health records each month to monitor compliance with test result communication requirements.

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

[18] 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).

Action Plans and Process Improvements

The OIG reviewed prior OIG and The Joint Commission accreditation survey results from the past three years prior to the inspection in December 2025 and found no unimplemented recommendations. Quality management employees explained they use several methods to track and ensure timely resolution of all recommendations from oversight bodies. For example, they hold weekly continuous survey readiness meetings (an ongoing proactive process to maintain accreditation compliance) and require all facility services to update the status of open action items and the progress toward completion. The Quality and Patient Safety Committee meets monthly, and services rotate reporting on performance measures and action items. Quality management employees follow up with teams, communicate trends, and escalate any action items with closure delays to executive leaders.

The Chief of Staff and quality management employees also described various ways they identify improvement opportunities. These include using information from the Joint Patient Safety Reporting system and conducting proactive and high-risk assessments, which evaluate processes to identify vulnerabilities and corrective actions before an adverse event occurs. Quality management employees use veteran satisfaction data and analyze safety incident trends monthly to ensure continuous patient safety and enhancements. They, and the Chief of Staff, reported sharing patient safety and process improvement information with leaders and facility employees through huddles, weekly clinical meetings, monthly service meetings, and patient safety forums, while also providing feedback to employees who report patient safety incidents. Quality management employees confirmed that executive leaders support improvement projects.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[19] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to VA Care

During a December 2025 interview, primary care leaders stated there were 107 primary care teams across the healthcare system and multiple vacancies for primary care providers, registered

[19] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care. VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

nurses, licensed vocational nurses, and medical support assistants. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* requires sufficient primary care staffing to ensure all patients receive appropriate health care.[20] The handbook also recommends staffing ratios of one primary care provider for every three full-time equivalent staff—a registered nurse, a licensed vocational nurse, and a medical support assistant.

Primary care leaders reported challenges meeting the recommended staffing ratios, citing resignations and retirements in 2025. They also described recruitment difficulties due to fewer licensed vocational nurse training programs, budget constraints and inadequate incentives for medical support assistants, rural clinic locations, and competition from nearby non-VA healthcare facilities that offer higher salaries and remote work options. In response, leaders said they were coordinating with human resources to post open positions. Additionally, gap providers (who are not assigned to a primary care team) previously handled walk-in patients but at the time of the inspection in December 2025 they covered provider vacancies and extended absences. This can result in longer wait times for both scheduled and walk-in patients.

Leaders stated the facility has seen significant growth in patient enrollment (approximately 1,000 per month). Leaders requested Veterans Integrated Service Network (VISN) approval to increase panel sizes (number of patients assigned to a primary care team) from 1,200 to 1,300 patients, although many panels already exceeded 1,300.[21] VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, recommends that a full-time physician have a baseline panel size of 1,200 patients.[22]

Wait times exceeded 20 days on average for scheduling new patient appointments. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[23] To improve timely access to care, leaders said that primary care teams audit their panels for inactive patients and adjust both appointments and provider schedules. The facility also opened weekend clinics and added new patient appointment slots at some community-based outpatient clinics to try to meet this target.

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

[21] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visn. In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5, with the new structure taking effect on June 1, 2026. All VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

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

[23] 38 C.F.R. § 17.4040 (2025).

Community Care Staffing and Access to Non-VA Care

Community care leaders reported a 20–30 percent increase in referrals to community providers for FY 2025 compared to FY 2024, and multiple vacant positions among the facility's program staff. Leaders explained the facility cannot accommodate the demand for some specialty care due to provider vacancies, which results in more community care referrals.

Community care employees spoke of safety concerns related to changes in consult processing because nurses no longer initially review them. They felt the nurses should guide the care and the administrative staff should assist them as needed. In addition, they asserted that vacancies have affected the workflow because community care employees must take on multiple responsibilities as a result, such as answering telephone calls from the facility's call center. Nurses also discussed with the OIG team in December 2025 their difficulties in providing follow-up for patients with complex and moderate care needs due to the increased workload and staffing vacancies. Employees said the increasing volume of consults and the vacancies create gaps in care. Employees also cited redundancies and inefficiencies because they work with multiple computer programs, such as the electronic health record system and the community provider's scheduling system, which do not communicate with each other. The OIG team found that community care staff scheduled appointments within approximately 18 days of when the consult was entered, exceeding the 7-day standard set out in VHA's *Consult Timeliness Standard Operating Procedure*.[24]

In response, community care leaders implemented workflow changes in late 2025, distributing workloads more equitably to address the demand. During the December 2025 interview, they stated the Resource Management Committee and the Chief of Staff approved hiring to fill all 23 vacant positions; however, leaders noted hiring challenges because job announcements must be initially posted internally before external candidates can be considered.

Facility community care leaders also told the OIG team that they received serious complaints from veterans related to quality and safety of care issues they experienced with some community care providers. These leaders reported they followed protocol to report the complaints to the third-party administrator (an external company that manages the contracts made with community providers in their network) but at the time of this inspection in December 2025, had not received any responses. The OIG inspection team referred this finding to another directorate within the VA OIG for further evaluation.

[24] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 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.[25]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[26] HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[27]

Performance and Improvement Highlights

- The facility fell short of the FY 2025 exit to permanent housing (HCHV1) target but met the negative exit (HCHV2) target. The facility's homeless program manager described a contract with a residential facility for 16 beds for male veterans that began in March 2025, which should help them meet the HCHV1 target.

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

[26] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 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 targets for HCHV2 at the national level each year. VHA Homeless Programs Office, VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

- During a December 2025 OIG interview, program employees described services offered at the facility's Community Resource and Referral Center. The center serves as a base for program staff and a specialized primary care team, which focuses on veterans experiencing homelessness. It also offers meals, laundry, hygiene services, transportation, and referrals to VA and community resources.
- In the same interview, facility program leaders reported the number of veterans served increased from about 5,000 in FY 2024 to about 11,000 in FY 2025, with 65–75 veterans visiting the Community Resource and Referral Center daily. Although the center's use grew, staffing fell from 12 to 5 after several employees left and positions were not filled due to hiring limitations. The loss increased workloads and delayed veteran access to 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 currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[30]

Performance and Improvement Highlights

- Facility program managers credited meeting the FY 2025 voucher use (HMLS3) target to collaboration with landlords, outreach events, creating better veteran access to resources, and more rural housing vouchers. Program managers emphasized maintaining strong relationships with landlords and hosting engagement and outreach events.
- Program managers added that they met the FY 2025 employment (VASH3) target because of the program's employment specialist who built community connections and organized résumé workshops. Veterans also use the facility's Community

[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 2025 Homeless Performance Measures.*

Resource and Referral Center and the Veterans Benefits Administration, both of which offer employment resources and services.

- Leaders and employees reported the program has 2,035 vouchers assigned, with 1,996 in use. The program has 88 positions, including social workers, nurses, peer support specialists, an employment specialist, an occupational therapist, and a physician assistant.

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.[31] 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).[32]

Performance and Improvement Highlights

- The facility met the FY 2025 enrollment (VJP1) target. Facility program employees credited success to adding a second team member for rural jail outreach, so they can now visit jails proactively instead of waiting to be contacted by jail officials. In addition, employees visited 46 prisons and four transitional housing programs for veterans discharged from prison to help them connect with VA and community resources.

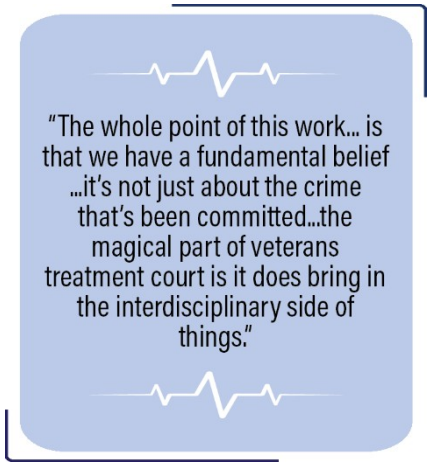

Figure 4. *Veterans treatment courts. Source: OIG interview the program lead.*

- Facility liaison documents show the program covers 30 counties, but the program lead told the OIG there are limited employees to meet demand. Program employees also said court officials in some rural areas want to start veteran treatment courts—which supervise veterans through a program that provides offenders with monitored treatment and other services—but the facility program lacks staff to support them.[33]

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

[32] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

[33] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at the VA Houston Healthcare System, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[34] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from December 15 through 18, 2025. 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 inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[35] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[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.

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

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

[36] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. 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 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.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 16, 2026

From: Director, Health Service Area 4.1

Subj: Healthcare Facility Inspection of the VA Houston Healthcare System in Texas

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

Chief Integrity and Compliance Officer (10OIC)

The Health Service Area 4.1 has reviewed the report and concurs with the finding of no recommendations from the Healthcare Facility Inspection of the VA Houston Healthcare System in Texas.

(Original signed by:)

Stephanie A. Repasky, Psy.D.
Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2026

From: Director, VA Houston Healthcare System (580)

Subj: Healthcare Facility Inspection of the VA Houston Healthcare System in Texas

To: Director, VISN 4 (10N4)

Thank you for the opportunity to review the Healthcare Facility Inspection of the VA Houston Healthcare System in Texas, Office of Inspector General (OIG) Report. I have reviewed the report and concur with the finding of no recommendations.

At the Michael E. DeBakey VA Medical Center and Houston VA Healthcare System, we are committed to the continued embodiment of High Reliability Organization principles and values. I appreciate our partnership with OIG to ensure that our Veterans whom we proudly serve continue to receive the highest quality of care as they deserve.

(Original signed by:)

Amir Farooqi, FACHE
Director

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.