US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Tuscaloosa Healthcare System in Alabama

Healthcare Facility Inspection	26-00038-262	September 4, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Tuscaloosa Healthcare System (the facility) from January 13 through 15, 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 15,200 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The team found that staff stored cleaning supplies in soiled utility rooms, which did not align with VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* and created contamination risks.[3] Further, despite prior awareness of the issue, a supervisor did not monitor or enforce corrective actions. The OIG made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. Inspectors found the facility did not have an updated policy for communicating test results, and leaders had not developed service-level workflows that designate the roles of providers and staff in communicating test results to patients, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[4] The OIG made one recommendation.

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[1] VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no 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." "Trip Pack–Operational Statistics Table FY2026 Through January," VHA Support Service Center, updated March 25, 2026, https://reports.vssc.med.va.gov/Report. (This web page is not publicly accessible.)

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

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

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

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[5] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have been recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director takes appropriate action so staff properly store cleaning supplies and leaders monitor corrective actions for sustained compliance, in accordance with Veterans Health Administration Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*.
2. The Director takes appropriate action so staff update the facility policy for communicating test results and develop service-level workflows that describe team members' roles in the process, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

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

VA Comments and OIG Response

The 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).[6] Based on information provided, the OIG considers recommendation 2 closed. For the remaining open recommendation, the OIG will follow up on the planned actions until they are completed.

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for Healthcare Inspections

[6] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

CLC	community living center
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 (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[7] 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.[8]

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.[9]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[10]

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.[11]

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

[8] 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.

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

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

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

The VA Tuscaloosa Healthcare System (the facility) has served veterans since 1932 and provides primary care, long-term care, rehabilitation, and mental health services. The facility had 319 beds across the community living center (CLC), domiciliary, psychiatry unit, and residential rehabilitation unit, and a fiscal year (FY) 2025 budget of over $350 million.[12]

Figure 1. *Facility photo.*
Source: "Tuscaloosa VA Medical Center," VA, accessed January 6, 2026, https://www.va.gov/tuscaloosa-health-care/locations.

The OIG team inspected the facility from January 13 through 15, 2026. The executive leaders referred to throughout this report include the interim Director (since December 2025), the Chief of Staff, the Associate Director, and the acting Associate Director for Patient Care Services (since December 2025). Quality management staff reported that the Associate Director had held a permanent position since January 2021, and the Chief of Staff became permanent in January 2026.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[13] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

[12] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://www.va.gov/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/clc. "Trip Pack–Operational Statistics Table FY2026 Through January," VHA Support Service Center, updated March 25, 2026, https://reports.vssc.med.va.gov/Report. (This web page is not publicly accessible.)

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

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

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

System Shocks

Executive leaders and facility staff reported two system shocks that disrupted operations and affected oversight, staffing, and quality of care. They were CLC (nursing home) operational changes and turnover among the executive leadership team.

Over three months in early 2025, the quality management team identified and monitored several concerning trends in the CLC, including an increased number of patient falls, dirty patient care areas, and insufficient oversight by nursing leaders. That team reported the issues to executive leaders. Additionally, the quality management team noted that because of staffing vacancies in the CLC, nurse managers routinely provided direct patient care, which limited their time for supervisory duties.

Executive leaders requested assistance from Veterans Integrated Service Network (VISN) leaders in May 2025 to review these concerns and develop a corrective action plan.[16] Approximately two weeks later, a VISN team inspected the CLC and recommended continued VISN oversight for an additional three months while executive leaders and staff worked on improving patient safety. Following the VISN inspection, executive leaders and staff led facility-wide efforts to enhance safety and quality of care. They changed the floor wax to reduce the risk of slipping, added more rehabilitation service staff to patient care treatment teams, and had a pharmacist review a patient's medications after a fall. The facility liaison provided data that showed the number of falls had decreased by November 2025.

However, in September 2025, there were not enough nursing staff to meet the needs of the CLC, and executive leaders paused admissions, consolidated the patient care areas from seven units to four, and reassigned CLC staff to those units. Executive leaders planned to restart admissions once staffing stabilized and hoped it would be within the year.

In addition, executive leadership turnover affected operations. In January 2026, executive leaders told the OIG that two of the four executive leadership positions were filled with acting or interim staff. The permanent Director retired in September 2025 and was replaced with an interim Director, who served for approximately three months. A new interim Director was appointed in December 2025 for a 120-day term. After the permanent Associate Director for Patient Care Services was reassigned to the VISN in June 2025, acting staff filled the position, and the fourth

[16] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

acting Associate Director for Patient Care Services began a 120-day appointment in December 2025. Also, the Chief of Staff was appointed to an acting role in October 2025, following the retirement of the previous Chief of Staff, and assumed the permanent position during the week of the inspection in January 2026.

The chief of quality management provided a June 2026 staffing update indicating that leaders were recruiting for the medical center director and associate director positions. Acting staff still filled the associate director for patient care services role.

The *Fiscal Year 2025 Inspector General's Report on VA's Major Management and Performance Challenges* highlighted a concern that reliance on acting leaders may produce only short-term fixes for organizational challenges.[17] Executive leaders echoed this concern, noting that frequent leadership changes and acting assignments made it difficult to implement long-term process improvements. Executive leaders explained that if process improvements extended beyond an interim leader's term, subsequent leaders might not continue the actions, which could result in lost resources and time. Leaders' responses to instability in these positions are discussed below in the Employee Experiences section.

Employee Experiences

Employees who responded to the OIG questionnaire expressed mixed opinions about the facility's culture. Just over one third agreed that the culture of the facility is moving in the right direction (see figure 2).

Executive leaders said employees became concerned about the facility's stability following the changes in executive leadership discussed above. The leaders in place at the time of the inspection in January 2026 addressed those concerns through transparent communications in town halls, morning operational briefings, and rounds (visits to employees in their work settings to discuss issues). Executive leaders reported receiving positive feedback from employees through the same channels.

Additionally, executive leaders empowered employees to suggest process improvements and included them in work groups to implement changes. As seen in figure 2, most OIG questionnaire respondents reported feeling comfortable suggesting actions to improve the work environment. Leaders stated that increasing their efforts to communicate and engage employees in workplace improvements also led to increased patient safety reporting.

[17] VA OIG, *Fiscal Year 2025 Inspector General's Report on VA's Major Management and Performance Challenges*.

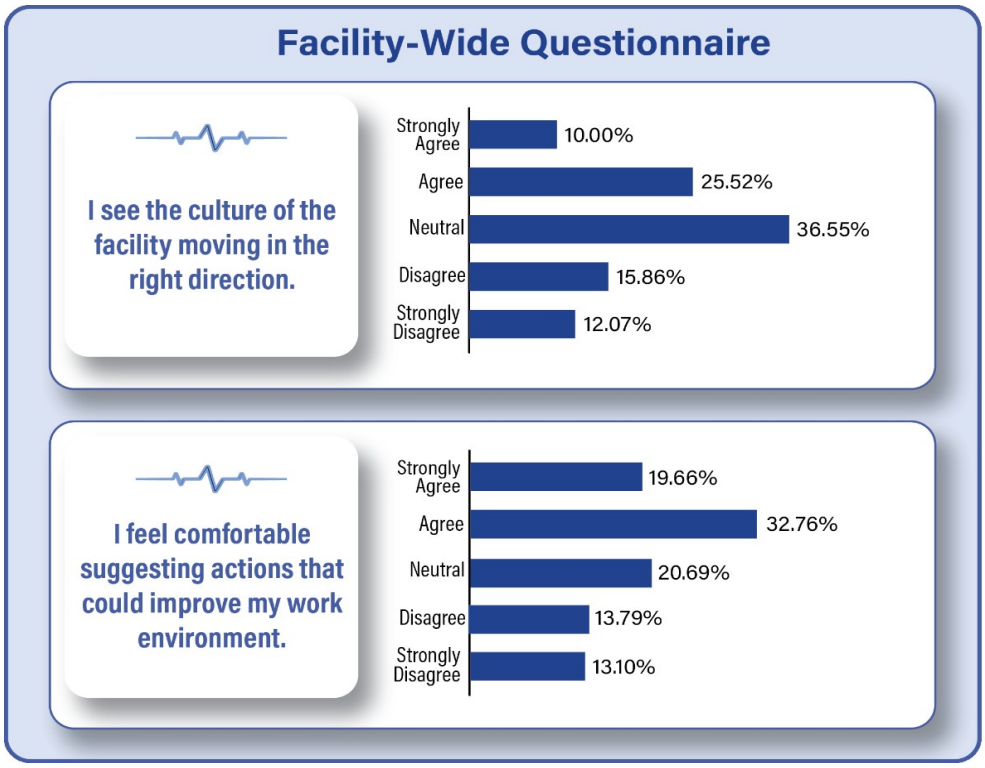

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

The facility's veteran trust scores declined from 94 to 93 percent from the second to third quarters of FY 2025. In response, executive leaders drafted a plan to improve veterans' overall experience, which included responding more quickly to veterans' concerns and reviewing trust scores weekly during morning operational briefings to monitor trends. Facility data showed trust scores reached 95 percent in the first two months of the first quarter of FY 2026, which was above VHA's national average of 94 percent.

Patient advocates said eligibility for VHA travel benefits was the main concern veterans expressed to them. To address this issue, the advocates and travel staff increased veteran education and promoted the use of VHA's online travel reimbursement system through messaging on facility media platforms, during veteran town halls, and in individual discussions.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[18] 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.[19]

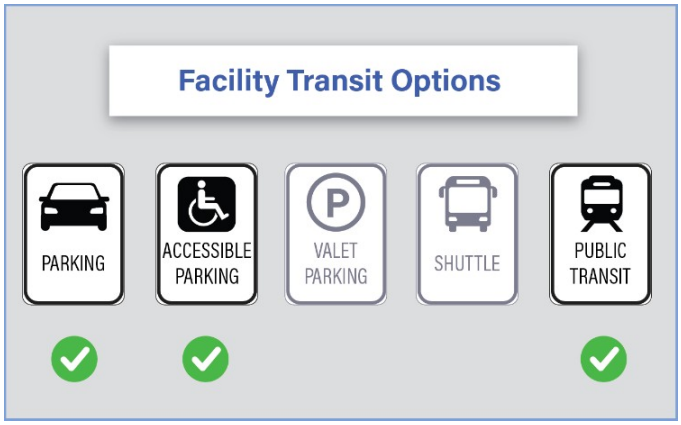

Figure 3. *Transit options for arriving at the facility. Source: OIG questionnaire responses and observations.*

General Inspection

On arrival at the facility, the OIG team followed signs to parking lots, which had accessible spaces for those with disabilities, emergency call buttons, and security cameras. Additionally, the team noted a public bus stop located within a short walking distance of the main entrance.

The main entrance featured a passenger loading zone with a canopy, power-assisted doors, and a wheelchair-accessible ramp. The area was well lit by natural light and included available seating and several wheelchairs for veterans' use.

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

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

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

Throughout the building, the OIG team saw clear and accurate signs. Directional markers were large and easy to read, and color-coded wall maps were posted to help veterans navigate to various departments. The team also noted check-in kiosks and braille in elevators. Staff at the main entrance were available to provide information. The deputy chief of quality management reported that veterans who were hearing-impaired had access to hearing aids and assistive listening devices.

While inspecting the primary and specialty care clinics and the CLC, the team found patient care areas to be clean, with personal protective equipment accessible for staff and no privacy issues. However, the OIG team identified several issues in the CLC, including damage to walls and a window frame, cardboard boxes (which can contain dust and pests that contaminate clean supplies) stored in a clean storage room, and a dirty ice and water dispenser. Staff corrected these issues during the inspection in January 2026. Therefore, the OIG did not make related recommendations.

The team also found cleaning supplies stored in soiled utility rooms, primary care clinic areas, and the CLC nutrition room, which contained a refrigerator and an ice and water machine. VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* requires executive leaders to ensure staff follow infection prevention and control practices, including separating soiled or contaminated items from clean ones.[20] Storing cleaning supplies in soiled utility rooms may spread pathogens to clean surfaces and increase the risk of infection for veterans and staff who use those spaces.

The environmental management services supervisor reported identifying this issue the week before the OIG inspection and instructing staff to remove the cleaning supplies. Staff also corrected these issues during the inspection. However, the OIG remains concerned that, despite leaders' awareness and prior discussions with staff, the environmental management services supervisor did not monitor and enforce corrective actions—prompting the OIG to make the following recommendation.

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

Recommendation 1

The Director takes appropriate action so staff properly store cleaning supplies and leaders monitor corrective actions for sustained compliance, in accordance with Veterans Health Administration Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs.*

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2027

Director Comments

The Environmental Management Services Supervisors will conduct brief, scheduled walk-throughs once monthly to verify that cleaning supplies are stored in designated, secure locations. Any issues identified will be documented, addressed immediately with staff, and tracked on a simple compliance log to ensure sustained adherence. The goal is to achieve at least 90% compliance with monthly walkthroughs in all patient care areas for 3 consecutive months.

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 found there was an established process for communicating test results between providers and patients, but the facility policy was outdated, and leaders had not developed service-level workflows that describe team member roles in the process. VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* required facilities to develop a policy and workflows for each clinical service to identify those who can notify patients of results, within 12 months of the directive's date.[21] Outdated policies might not include accurate information for staff to provide safe and appropriate care. In addition, the absence of service-level workflows could delay the communication of test results and follow-up care.

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

Recommendation 2

The Director takes appropriate action so staff update the facility policy for communicating test results and develop service-level workflows that describe team members' roles in the process, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients.*

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Staff developed an updated facility policy for communicating test results and development of service-level workflows that describe team member roles.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

The chief of quality management stated that their staff review electronic health records to confirm providers document their communication of test results to patients. VHA Directive 1088(1) states that providers must communicate test results that require action to patients within seven days of the results becoming available. Data for the first two quarters of FY 2025 showed that the facility's compliance with communicating test results that require action within the required time frame was 82 percent, above the national average of 81 percent.

However, a supervisor reported delays in communicating radiology test results after radiologists left their position at the facility. According to the supervisor, many radiologists retired after the return to in-person work mandate.[22] Because no facility radiologists worked on-site at the time of the inspection, staff sent all radiology exams to the National Teleradiology Program (whose off-site radiologists provide virtual imaging results). The supervisor explained the program had a backlog, which increased the amount of time it took for providers to receive results.

Also at the time of the site visit in January 2026, radiology test results that were not critical or were not for life-threatening emergencies took four to eight days to reach facility staff. The Chief of Staff added that when providers needed results more quickly, they called the program directly and usually received a speedier response. Additionally, the chief stated that even with the

[22] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025).

radiology delays, staff relayed most test results requiring action to patients within seven days, as required by VHA Directive 1088(1).

Action Plans and Process Improvements

The inspection team reviewed previous OIG reports and found that leaders had not implemented corrective actions for one recommendation from a September 2025 review of a patient's mental health care at the facility. The recommendation was related to education about applicable black box warnings (safety alerts for high-risk, serious, or potentially deadly medication side effects) for patients who receive those medications for mental health care.[23] At the time of the inspection in January 2026, the chief of quality management stated the recommendation related to black box warnings was part of a long-term project that facility staff were still implementing.

During an interview, quality management staff said they collaborated with other facility staff to identify opportunities for improvement during rounds and tiered huddles (morning meetings with leaders and staff), and through executive leaders and service chief suggestions. When asked how staff receive information about process improvements, the patient safety manager described an innovation they call *Eagle Eye on Safety*. In this initiative, executive leaders semiannually recognize successful projects during facility town halls and present an eagle statue to the group or service that showed improvement, and to staff members who exemplify high reliability organization principles and values related to patient safety.[24]

According to quality management staff, executive leaders have supported the patient safety program. For example, the systems redesign coordinator described a training event attended by 26 leaders, including service chiefs and executives, that focused on leaders' roles in the facility's journey toward continuous process improvement and zero harm. This was significant given that facility staff identified executive leader turnover as a system shock that affected facility operations at the time of the inspection in January 2026.

[23] VA OIG, *Mismanaged Mental Health Care for a Patient Who Died by Suicide and Review of Administrative Actions at the VA Tuscaloosa Healthcare System in Alabama*, Report No. 23-02393-250, September 26, 2024.

[24] High reliability organizations focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings. Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[25] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

In January 2026, there were two registered nurse vacancies; however, three float nurses (who are not assigned to a team) were available to assist primary care teams as needed. The assistant manager attributed the low number of nursing vacancies to a favorable work schedule, with no weekend, evening, or holiday shifts. The Chief of Staff reported no issues with physician recruitment or retention, and two gap providers (physicians or nurse practitioners who cover planned or unplanned leave) were available when needed. The Chief of Staff and assistant nurse manager for primary care credited strong retention to engaged primary care leaders who listened to staff concerns and consistently followed up on issues.

Primary care leaders reported their targets for panel sizes (the number of patients assigned to a care team) were 1,200 patients for physicians and 900 for nonphysician providers, which reflect baseline capacities in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.[26] The OIG found that 4 of the 16 teams were over the baseline capacity. On average, panel sizes were about 85 percent of capacity, and no team exceeded the 105 percent maximum panel capacity set by the facility.

To ensure sizes remained manageable, the patient centered management module coordinator (who is responsible for calculating, adjusting, and monitoring panel sizes) and the Chief of Staff met weekly with primary care nurse managers, the associate chief nurse of primary care, and the health system specialist to review panel data and monitor providers' workload. They did not add new patients to panels exceeding 105 percent of capacity.

The facility's average wait time for established patient appointments in FY 2025 was 6 days. However, wait times for new patients averaged 21 days, which under the Code of Federal Regulations (title 38, section 17.4040) meant they met wait-time criteria for referral to

[25] "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.

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

community providers (more than 20 days).[27] In response, the Chief of Staff increased weekly new patient appointment slots from five to seven for each provider, retrained medical support assistants on managing slots, and added Saturday clinics, which reduced new patient wait times to an average of 16 days in the first quarter of FY 2026.

Community Care Staffing and Access to Care

At the time of the inspection in January 2026, the chief of community care reported five staffing vacancies within the facility's program: a registered nurse, an advanced medical support assistant, an advanced medical support assistant supervisor, a lead advanced medical support assistant, and a data analyst. According to the acting Associate Director for Patient Care Services, the previous Director approved recruiting for the lead advanced medical support assistant and data analyst positions to meet the most important community care staffing needs.

The OIG found that between October 1, 2024, and September 30, 2025, the facility's community care staff took an average of 10 days to schedule appointments, which was longer than the 7-day time frame required by VHA's *Consult Timeliness Standard Operating Procedure*.[28] The chief emphasized the major challenges were increases of over 9,600 community care referrals and more than 8,500 requests for additional services (for services not already approved under the VHA referral) from FY 2022 to FY 2025.[29]

To improve efficiency and reduce wait times, the chief of community care reported redistributing tasks among medical support assistants and registered nurses to better balance workloads. However, the chief emphasized that despite these efforts, hiring additional staff, specifically advanced medical support assistants, was necessary to manage the significantly increased volume of referrals. The chief also noted increased appointment wait times due to limited availability of community providers, especially rheumatologists and endocrinologists, and reported working with the third-party administrator (a company that VHA contracts with to create a regional network of community care providers) to add more specialty care providers.

[27] 38 C.F.R. § 17.4040 (2025).

[28] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," June 12, 2025.

[29] VHA Office of Integrated Veteran Care (IVC) Community Care, "How to Coordinate Care in the Community," chap. 3 in *Community Care Field Guidebook*, April 1, 2026.

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.[30]

VHA uses performance measures to determine the success of each 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).[31] HCHV2 measures the percentage of veterans who are discharged from the 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)."[32]

Performance and Improvement Highlights

- VHA excluded the facility from the permanent housing (HCHV1) and negative exit (HCVH2) performance measures because it did not offer contracted emergency residential services or low-demand safe haven programs. The supervisory social worker for homeless programs stated the facility canceled its contracted residential care in 2017 due to concerns about the agency providing the services.

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

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

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

- Facility program staff referred veterans who need transitional housing to community options or the facility's residential rehabilitation and treatment programs, which began accepting same-day and weekend admissions in 2025 to provide emergency housing.[33] Staff also directed veterans who needed housing in rural counties outside of Tuscaloosa to local housing support agencies.
- In addition to assistance with immediate shelter and permanent housing, program staff helped veterans find employment and obtain medical and mental health care.

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."[34] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[35]

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).[36]

Performance and Improvement Highlights

- The facility program exceeded the voucher use (HMLS3) target for FY 2025. The supervisory social worker attributed this success to program administration changes. At the time of the inspection in January 2026, the supervisor said two facility program staff members focus on building relationships with landlords and helping veterans find housing, which has reduced placement delays and increased voucher use.
- Program staff also successfully secured permanent housing for veterans who are unable to live independently due to medical or mental health conditions. The facility was the first in the VISN to use vouchers for the Community Residential Care and Medical Foster

[33] The facility offers several residential rehabilitation and treatment programs to address mental health and substance use disorders and meet the needs of veterans experiencing homelessness. Tuscaloosa VA Medical Center, "Mental Health," chap. 2 in *Guide to Services for Veterans and Families*, January 2020.

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

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

[36] 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.*

Homes programs, which provide room, board, and additional services such as personal care and medication supervision.[37]

- Additionally, the facility program met the employment (VASH3) target in FY 2025. The facility program coordinator attributed this to retraining staff on how to correctly enter employment data in the homeless program database.

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.[38] 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).[39]

Performance and Improvement Highlights

- The facility program did not meet the enrollment (VJP1) target in FY 2025. The veterans justice outreach social worker expressed the belief that fewer veterans needed the program in FY 2025.
- The supervisory social worker for homeless programs said staff engage with more than 40 veterans in one of the four veterans treatment courts in the facility's coverage area.[40] The veterans justice outreach social worker and the social work supervisor reported that over 78 percent of veterans in the program are on a dismissal track (in which the judge removes charges when veterans meet certain conditions, such as completion of a substance abuse treatment program). Staff explained that being cleared of charges, including misdemeanors and sometimes felonies, can change the life path of a veteran, which results in greater access to employment and housing.

[37] VHA Directive 1140.01(1), *Community Residential Care Program*, April 1, 2020, amended September 24, 2021; VHA Directive 1141.02, *Medical Foster Home Program*, February 7, 2024.

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

[39] 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.*

[40] 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 VA Tuscaloosa Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to the storage of cleaning supplies, as well as service-level workflows and the facility policy for communicating test results. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 2. 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 team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[41] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG team interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the team physically inspected various areas of the medical facility from January 13 through 15, 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[42] 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.*[43]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[44] 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.

[41] The accreditation reports covered the time frame of October 1, 2023, through December 31, 2025—the most recent available at the time of the inspection.

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

[43] 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.

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[45] 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.

[45] 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: August 18, 2026

From: Acting Executive Director, VA Health Service Area 2.2

Subj: Healthcare Facility Inspection of the VA Tuscaloosa Healthcare System in Alabama

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Healthcare Facility Inspection of the VA Tuscaloosa Healthcare System in Alabama. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I reviewed the action plan provided by the facility and concur with the response.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
3. Should you have any questions or require further information, please contact the Regional Quality Management Officer.

(Original signed by:)

Benita K. Miller, FACHE, LISW-CP

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 11, 2026

From: Director, VA Tuscaloosa Healthcare System (679)

Subj: VA OIG Report, Healthcare Facility Inspection of the VA Tuscaloosa Healthcare System in Alabama

To: Acting Executive Director, VA Health Service Area 2.2

We appreciate the opportunity to review and comment on the OIG draft report. The Healthcare System concurs with the recommendations and will take corrective action.

Should you need further information, please contact the Chief of Quality Management.

(Original signed by:)

Maisha Moore, DNP, RN, CNL, NEA-BC, VHA-CM
Interim Medical Center Director

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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.