US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Southern Arizona VA Health Care System in Tucson

Healthcare Facility Inspection	26-00045-263	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 Southern Arizona VA Health Care System (the facility) from February 10 through 12, 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 66,000 patients.[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 have been 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 December," VHA Support Service Center, updated February 4, 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).[4] No further action is required.

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[4] 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

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.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

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

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

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

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.[9]

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[5] "About VHA," VA, last updated June 2, 2026, https://www.va.gov/aboutvha.

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

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

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

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

The Southern Arizona VA Health Care System (the facility) includes a medical center and a mobile medical unit in Tucson and nine community-based outpatient clinics in Casa Grande, Green Valley, Sierra Vista, Tucson, Safford, and Yuma. In fiscal year (FY) 2025, the medical care budget was approximately $1.1 billion. The facility had 174 hospital, 25 domiciliary, and 90 community living center beds and served more than 66,000 veterans.[10]

Figure 1. *Facility photo.*
Source: "VA Southern Arizona Health Care," VA, accessed February 5, 2026, https://www.va.gov/southern-arizona-health-care.

The OIG team inspected the facility from February 10 through 12, 2026. The executive leaders referred to throughout this report include the interim Director, Chief of Staff, Deputy Chief of Staff, Associate Director for Patient Care Services, Deputy Associate Director for Patient Care Services, acting Associate Director, and acting Assistant Director. The executive leaders have worked together since October 2025, when the acting Assistant Director was temporarily assigned to the position.

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.[11] 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).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

[10] 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/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.

[11] 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.

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

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

System Shocks

Executive leaders identified leadership transitions, a recent unexpected surge of patients in the emergency department, and loss of chillers (which help distribute cool air) during the previous summer in an inpatient unit and operating room as system shocks.

The leaders said the former Director left at the end of June 2025. In July, the Associate Director became the interim Director and the Assistant Director moved to the acting Associate Director role. The acting Assistant Director was temporarily assigned from another VA facility in October 2025.

Because the interim Director and acting Associate Director already held executive leadership positions, they maintained communication and conflict management processes to provide structure through the transitions. Leaders reported focusing on bidirectional communication with facility leaders and frontline employees—providing input, developing plans, receiving feedback, and making decisions.

Executive leaders discussed the chiller failure during the summer of 2025. The problem caused temperatures to rise in an inpatient unit and an operating room special-procedure unit. Leaders and employees moved 24 patients to other units within two hours and reassigned employees to support patient care. The leaders also explained that a service leader ensured employees moved patients' high-risk procedures to other treatment areas, and rescheduled patients awaiting routine procedures to the following week. In addition, they updated service leaders, employees, and patients on the facility's operating status.

Executive leaders also described the surge of more than 20 patients in the emergency department who were admitted for inpatient treatment during a shift in early 2026. The leaders activated an incident command center (a flexible management system VA medical facilities use to establish "responsibilities and reporting channels" when responding to an event) and opened 10 additional beds.[14] They also had employees from mental health, specialty care, and social work services help care for patients. The leaders visited the unit with the additional beds throughout the week-long event to help move patients as needed.

[14] VHA Directive 0320.12(1), *National Incident Management System Compliance*, December 8, 2020, amended January 25, 2021.

Employee Experiences

Executive leaders said they engage with employees through monthly town halls and routine visits throughout the medical center and community-based outpatient clinics. The leaders also stated they increased efforts to recognize employees and presented awards at town halls, quarterly events, and unit meetings.

According to the leaders, they distributed an employee feedback survey in December 2025, which identified burnout and communication as key issues. Approximately 51 percent of respondents reported experiencing some symptoms of burnout. Respondents also indicated they wanted explanations for decisions, more information on how changes will affect their work, and more clarity in communications. After the survey, the leaders summarized the results for employees, and service leaders reviewed their department's action plans and updated them as needed.

Veteran Experiences

The OIG team found that the facility's VSignals scores for trust and confidence in the facility ranged from 93 to 95 percent in the first three quarters of FY 2025. Executive leaders attributed the scores to community support and employees' commitment to veterans' care. The leaders also reported they maintained high visibility through routine interactions with veterans at the facility and participated in community events.

Additionally, executive leaders described the facility's *Hero's Welcome* process for veterans admitted to the medical center—a volunteer greets each veteran, reviews a packet of information, and checks back with them throughout the admission. Volunteers also visit inpatient units to gather veterans' feedback and relay concerns to leaders.

Executive leaders stated veterans can share complaints or concerns directly with leaders or through the Veterans Experience Office. Patient advocates then work with designated employees to resolve issues within each service.

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

The OIG team noted that the Tucson area's public transit system provides free service and has bus stops next to the facility, and an electric tram transports veterans across the site. The team observed parking lots with accessible spaces for individuals with mobility challenges.

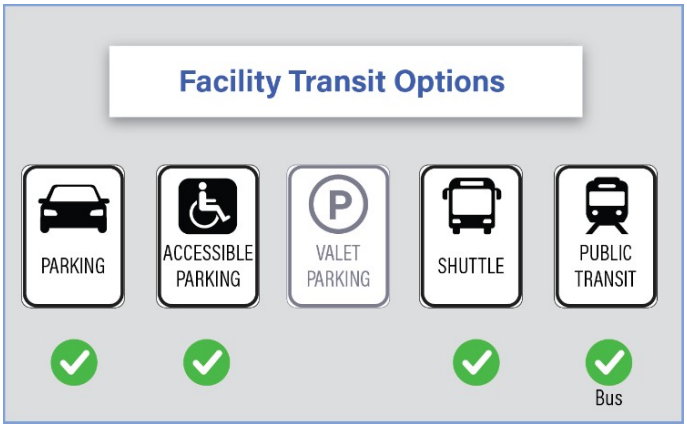

Figure 2. *Transit options for arriving at the facility. Source: Documents describing facility processes, parking lot map, and facility liaison responses to an OIG questionnaire.*

The main entrance featured a covered drop-off area and automatic double doors. The team observed sufficient light and seating in the lobby. Volunteers welcomed veterans at an information desk, where they provided wheelchair transport or assistance in finding destinations. Additional concierge desks were located throughout the facility. A store for veterans was located next to the lobby.

[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.

Figure 3. *Accessibility tools available to veterans with impairments.*
Source: A parking lot map, team observations, and facility liaison responses to an OIG questionnaire.

Inspectors observed directional signs and maps to guide veterans throughout the interior and exterior of the facility. Through observations and facility documents, the team confirmed that assistive devices were available for individuals with impairments.

The team also inspected the community living center, inpatient acute care and intensive care units, and outpatient primary care clinics. These areas were organized and clean. Supply and medication rooms contained no expired items and were properly secured. Medical equipment displayed current inspection stickers, and items were appropriately cleaned, tagged, and stored. Personal protective equipment (masks and gloves) was readily available, and patient privacy was protected.

However, before the OIG's inspection in February 2026, the team reviewed the facility's FY 2025 Annual Workplace Evaluation, conducted by the Veterans Integrated Service Network (VISN), which noted a problem with the Respiratory Protection Program.[17] The facility was unable to provide a comprehensive list of employees authorized to wear respirators (masks to protect employees from inhaling harmful airborne contaminants), or show they conducted the associated annual testing to ensure the masks fit properly (fit testing).

Title 29 of the Code of Federal Regulations (section 1910.134(c)(e)(f)), requires employers to provide medical evaluations before employees use respirators, when employees have physical changes that can affect fit, and at least annually.[18] While at the facility, the OIG team interviewed Environment of Care Committee members, including the industrial hygienist. They

[17] VISN 22, *Annual Workplace Evaluation*, September 19, 2025, updated November 19, 2025; 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.

[18] 29 C.F.R. 1910.134(c)(e)(f) (2025).

still could not provide a comprehensive list of employees who could wear respirators, evidence of annual fit testing, or a plan to meet these requirements.

In a follow-up document provided to the OIG team, dated May 11, 2026, facility leaders outlined steps taken to improve fit testing, including issuing an updated medical center policy for the Respiratory Protection Program and informing service chiefs of the requirements for employees at risk of exposure. The service chiefs also provided the names of current employees who meet criteria for testing. On June 4, 2026, the facility reported 93 percent compliance with testing requirements. The facility met their stated goal to reach 90 percent compliance by June 30, 2026. For these reasons, the OIG did not make a recommendation.

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 team determined the facility has policies and processes to communicate abnormal test results to providers and patients, ensure coverage when a provider is unavailable, and notify providers of results from community care. During an interview, the Chief of Staff, the Associate Director for Patient Care Services, the chief of quality management, and quality management employees stated that when a provider is not available, employees use an application with a provider contact list to notify the designated surrogate or alternate provider. They also stated the facility has implemented backup reviewer processes to ensure coverage during provider absences.

Quality management employees explained that they review External Peer Review Program data quarterly to assess compliance with requirements for test result communications, then they share the findings with the Quality and Patient Safety Board and executive leaders. For FY 2025, the facility's compliance rate averaged 90 percent or higher for providers communicating test results to patients within seven days, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[19]

The Chief of Staff, the Associate Director for Patient Care Services, the chief of quality management, and quality management employees attributed the program's success to tailoring notifications of test results in the electronic health record system for each provider, who receives

[19] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review provider compliance with communicating test results to patients and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

a weekly email with the number of potential critical alerts assigned to them. Providers also received training during onboarding, and health informatics employees worked with them to optimize notification settings. The group further explained that an automated system creates letters with test results to send to patients, which helps reduce communication delays and provider workload. Additionally, they stated that primary care nurses can communicate normal results and some abnormal results to patients, with the provider's approval.

Action Plans and Process Improvements

The facility had no oversight recommendations related to test result communication during the three years prior to the OIG's February 2026 inspection. The chief of quality management and quality management employees explained that when an oversight body issues recommendations, they monitor the action plans, report progress monthly to the Quality and Patient Safety Board, and ensure employees sustain improvements.

During an interview, leaders and quality management employees stated they review entries in the Joint Patient Safety Reporting system (a database where employees document patient safety events, including medical errors and close calls); conduct daily tiered huddles (brief meetings where employees discuss patient safety issues); and host monthly patient safety forums.[20] In October 2025, leaders launched the Good Catch Program to encourage employees to report patient safety concerns and provide feedback on process improvements.[21] Quality management employees added that executive leaders support patient safety through ongoing process improvement training, and by sharing patient safety stories and lessons learned throughout the facility.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[22] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders

[20] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook, Version 6.0*, October 2025; "VHA National Center for Patient Safety, Patient Safety Huddle Board," VA, accessed February 16, 2025, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.

[21] Naseema B. Merchant, et al., "Development of a Safety Awards Program at a Veterans Affairs Health Care System: A Quality Improvement Initiative," *Journal of Clinical Outcomes Management* 30, no. 1 (January 2023): 9–16, https://doi.org/10.12788/jcom.0120.

[22] "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.

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

At the time of the February 2026 inspection, primary care leaders reported and provided documents that confirmed the facility had several provider vacancies, as well as vacancies for registered nurses, licensed practical nurses, and medical support assistants across 64 primary care teams. Leaders stated they had several ways to cover vacancies, such as using gap providers (who are not assigned to a specific team) and providers from other government agencies, as well as having nurses cover multiple teams.

Primary care leaders added that nine provider vacancies were in active recruitment, and six candidates had tentative job offers. Also, the leaders said they plan to add three new primary care teams and have partnered with a local medical school residency program to support provider recruitment. In February 2026, the facility's average appointment wait time was under 20 days, which according to the Code of Federal Regulations (title 38, section 17.4040) meant patients did not meet wait-time criteria for referrals to community providers (more than 20 days). However, leaders acknowledged that current staffing levels may make these wait times difficult to sustain.[23]

Community Care Staffing and Access to Care

At the time of the inspection in February 2026, the OIG reviewed facility community care documents that showed no clinical or administrative vacancies. However, community care leaders and employees reported that referral volumes had increased between FY 2024 and FY 2025. They attributed this to the loss of specialty care providers at the facility and growth in the number of patients eligible for community care.

To address workload demands and referral scheduling delays, community care leaders authorized overtime. They also created a trainer position to support ongoing employee education in community care processes. The trainer reviews guidance and internal workflows, conducts monthly training, and issues updates when processes change. The trainer also conducts outreach and enrolls community providers in shared electronic systems, which allows facility community care staff to schedule appointments in community clinics themselves. Leaders stated that these initiatives reduced average scheduling times from 18 days in FY 2024 to 15 days in FY 2025 and 13 days as of March 2026, which is progress toward meeting the requirement of 7 days, according to VHA's *Consult Timeliness Standard Operating Procedure*.[24]

[23] 38 C.F.R. § 17.4040 (2025).

[24] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," updated 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 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 met the exit to permanent housing (HCHV1) target for FY 2025 but did not meet the negative exit (HCHV2) target. During an OIG interview, facility program employees attributed missing the HCHV2 target to high turnover among contracted case managers, which affected the process for veterans leaving the

[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, *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, *Technical Manual: FY 2025 Homeless Performance Measures.*

contracted residence for permanent housing. Program employees reported that staffing at the contracted residence stabilized in October 2025.

- Program employees reported they operate a Monday-through-Friday walk-in clinic that provides case management as well as access to showers, laundry, and a food pantry. The clinic serves 12 to 14 veterans per day.
- The employees also said they accompany the facility's homeless primary care team on community trips with the mobile medical unit to provide primary care and housing assessments for unsheltered veterans. This brings services to veterans without requiring them to visit the facility.
- Additionally, the employees discussed two outreach events the program held in the past year that resulted in housing for more than 50 veterans. The first event offered medical screenings, mental health services, access to food and hygiene services, and pet supplies, while the second event focused on housing placements.

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

- In FY 2025, the facility met both the voucher use (HMLS3) and employment (VASH3) targets. However, facility program employees identified barriers in meeting the HMLS3 target, including increased workload after staff departures, delays in voucher processing caused by a local public housing agency's budget

[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.*

shortfall, and increasing rents. Employees said they worked with community partners to ensure veterans remained temporarily housed during the delays.

- Program employees told the OIG that the Tribal HUD-VASH program, a national initiative that serves American Indian and Alaska Native veterans on and off reservations, used most of its allocated vouchers and accessed additional housing through funding partnerships with community organizations. Employees attributed the program's success to positive engagement with tribal traditions.

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 enrollment (VJP1) target for FY 2025. Facility program employees said they work with the criminal justice system to support veterans through crisis management and deflection teams (who offer alternative interventions to avoid incarceration). They participate in court proceedings and probation processes. Employees also work with community partners to help veterans access legal clinics and court-mandated education at a reduced cost.
- Program employees provide services to 5 veteran treatment courts (judicially supervised, multi-phase treatment programs), 6 jails, and 12 prisons.[33] They also participate in community and tribal outreach events.

[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 Southern Arizona VA Health Care System, the OIG conducted an inspection across five domains. The OIG did not make recommendations following this inspection. 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. 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 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 from February 10 through 12, 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.[34] 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.*[35]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[36] 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[37] The OIG reviews available evidence within a

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

[35] 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.

[36] 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.

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

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 17, 2026

From: Health Service Area 5.3 Director, VISN 5

Subj: VAOIG Draft Report-Healthcare Facility Inspection of the Southern Arizona VA Health Care System in Tucson

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the VAOIG Draft Report-Healthcare Facility Inspection of the Southern Arizona VA Health Care System in Tucson. I have completed a full review of the draft report.
2. I concur with the report, which included no recommendations.
3. Please contact the VISN 5-HSA 5.3 Interim Regional Quality Officer for questions or if additional information is needed.

(Original signed by:)

Walt Danneberg, FACHE
Health Service Area 5.3 Director, VISN 5
Veterans Health Administration

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 24, 2026

From: Executive Director, Southern Arizona VA Health Care System (678/00)

Subj: VAOIG Draft Report-Healthcare Facility Inspection of the Southern Arizona VA Health Care System in Tucson

To: Director, VISN 5 (10N5)

1. Thank you for the opportunity to review the VAOIG Draft Report-Healthcare Facility Inspection of the Southern Arizona VA Health Care System in Tucson. I have completed a full review of the draft report.
2. I concur with the report, which included no recommendations.
3. Please contact the Quality & Patient Safety Chief for questions or if additional information is needed.

(Original signed by:)

Leslie Lockridge, DNP, RN
Executive Director
Southern Arizona VA Healthcare System
U.S. Department of Veterans Affairs

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.