



# US DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

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## VETERANS HEALTH ADMINISTRATION

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### Healthcare Facility Inspection of the VA North Texas Health Care System in Dallas

Healthcare Facility  
Inspection

26-00055-01

October 8, 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 North Texas Health Care System in Dallas (the facility) from April 7 through 9, 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to more than 164,000 veterans.<sup>1</sup> The inspection team examined aspects of care delivery and patient safety within the facility using five domains.<sup>2</sup>

### 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.<sup>3</sup>
- **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 recently been incarcerated.

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<sup>1</sup> 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 FY2025 Through September," VHA Support Service Center, last updated March 17, 2026, <https://reports.vssc.med.va.gov/ReportViewer>. (This web page is not publicly accessible.)

<sup>2</sup> See appendix A for a description of the OIG's inspection methodology.

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

## **What the OIG Recommended**

The OIG made no recommendations.

## **VA Comments and OIG Response**

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



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## **Abbreviations**

|          |                                                                   |
|----------|-------------------------------------------------------------------|
| ADPCS    | Associate Director for Patient Care Services                      |
| 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                               |

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## 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.<sup>4</sup> 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.<sup>5</sup>



**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.<sup>6</sup>



**Patient Safety:** VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.<sup>7</sup>



**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.<sup>8</sup>

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

<sup>5</sup> 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>.

<sup>6</sup> VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

<sup>7</sup> VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

<sup>8</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA North Texas Health Care System in Dallas (the facility) provides services to 38 counties in Texas and 2 in Oklahoma. It includes the Dallas VA Medical Center, Garland VA Medical Center, Sam Rayburn Memorial Veterans Center in Bonham, several community-based outpatient clinics, and a community resource and referral center.<sup>9</sup> In fiscal year (FY) 2025, the facility had an operating budget of approximately \$2.6 billion. It had 263 acute care, 188 community living center (CLC), 13 compensated work therapy, and 110 domiciliary beds.<sup>10</sup>



**Figure 1.** Dallas VA Medical Center, part of the VA North Texas Health Care System.

Source: “Locations,” VA, accessed March 17, 2026, <https://www.va.gov/north-texas-health-care>.

The OIG team inspected the facility from April 7 through 9, 2026. The executive leaders referred to throughout this report include the Medical Center Director (Director); Chief of Staff; two Associate Directors; Associate Director for Patient Care Services (ADPCS); Deputy ADPCS for Patient Flow; Deputy ADPCS for Outpatient, Ancillary, and Spinal Cord Injury; and Assistant Director for Outpatient Services. The ADPCS, assigned in January 2017, had the longest tenure, and the Chief of Staff, who started in August 2025, was the newest executive leader.



## 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.<sup>11</sup> 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

<sup>9</sup> The facility operates clinics in Decatur, Denton, Granbury, Grand Prairie, Greenville, Sherman, Tyler, Plano, and two each in Dallas and Fort Worth.

<sup>10</sup> “About Us,” VA, last updated April 29, 2025, <https://www.va.gov/north-texas-health-care>; 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>. Compensated work therapy “provides evidence based and evidence informed vocational rehabilitation services” for veterans as well as other supports and partnerships for employment. “Compensated Work Therapy,” VA, last updated June 15, 2026, <https://department.va.gov/vha/cwt>. A domiciliary is a residential “clinical rehabilitation and treatment program” for veterans. “Domiciliary Care for Homeless Veterans,” VA, accessed June 29, 2026, <https://department.va.gov/homeless/dchv>.

<sup>11</sup> 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>.

assess their level of trust in VA).<sup>12</sup> The team also interviewed executive and facility leaders and employees and considered data from patient advocates.<sup>13</sup>

## System Shocks

The Director, Associate Directors, ADPCS, and Chief of Staff reported that an August 2024 water pump failure in the chiller system at the Dallas facility changed clinical operations and disrupted patient care. The failure resulted in increased temperatures in the inpatient care area of the hospital, requiring employees to move 124 patients and critical supplies to other areas. They relocated 75 patients to open beds in unaffected units and converted a gymnasium into an area to accommodate the remaining 49 patients.

The Director said leaders stood up an incident command system (a standardized organizational structure to manage operations during an emergency) in the conference room next to the gymnasium to facilitate communications with employees.<sup>14</sup> Employees repaired the water pump and returned all patients to their original units within 48 hours, and the Director indicated there were no resulting negative patient outcomes. The Director and Associate Directors also stated they upgraded the facility's chiller system to ensure employees could quickly identify and fix issues in the future.

## Employee Experiences

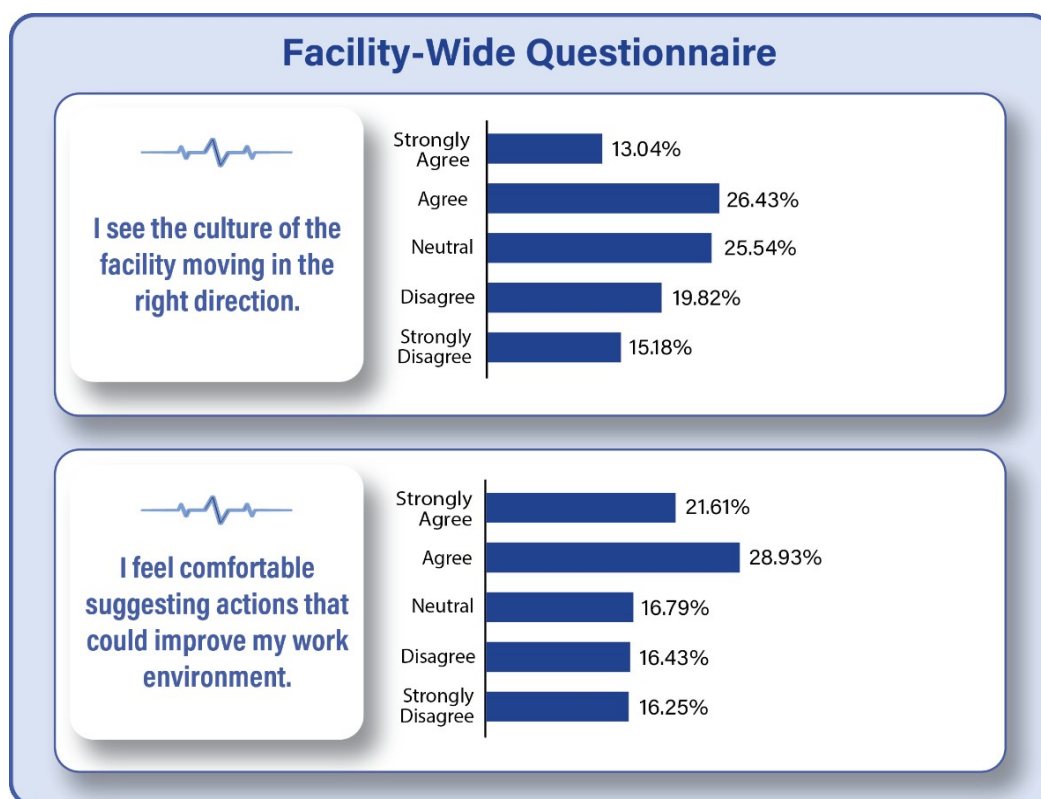
As shown in figure 2, 35 percent of respondents to the OIG questionnaire indicated they had concerns about the direction of the facility's culture, while more than half reported feeling comfortable suggesting actions that could improve their work environment. The Director, ADPCS, and veteran experience officer described several initiatives they took to improve employees' experiences, including the *ValYOUable Boutique*, where an employee can select VA apparel and other items as part of a recognition award.

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

<sup>13</sup> 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.

<sup>14</sup> VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

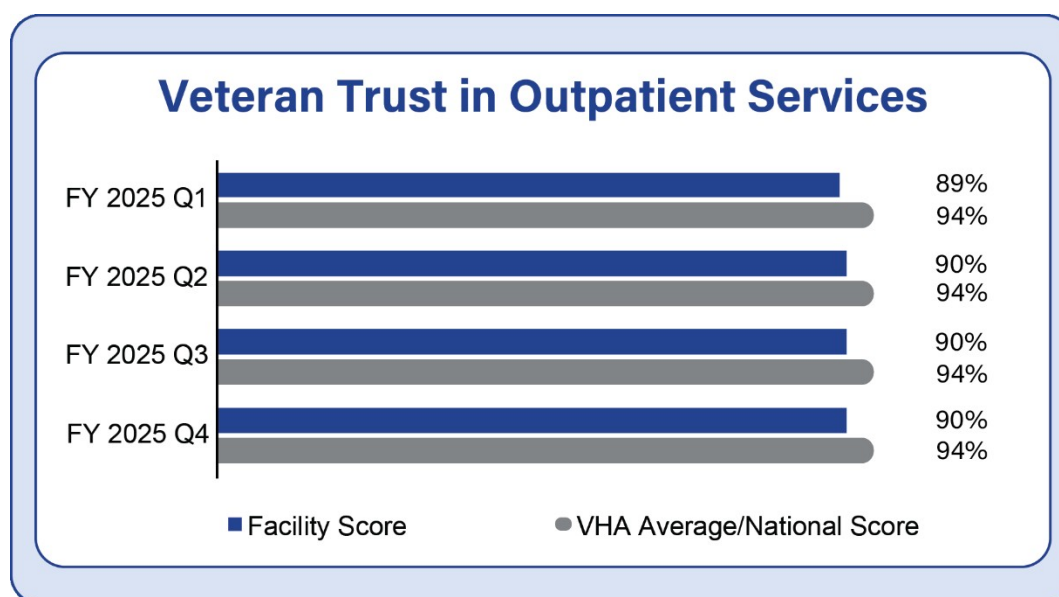


**Figure 2.** Employee perceptions of facility culture.  
Source: OIG analysis of selected questionnaire responses.

The Director and the Chief of Staff communicated with employees regularly through a weekly Director’s video message and monthly town halls. Most respondents to the OIG questionnaire indicated that leaders’ communications were clear, useful, and frequent. Additionally, more than half said they continue working at the facility because of the VA mission of caring for veterans. However, stress and burnout were the top responses employees considered as reasons for leaving the facility. In May 2025, the leaders developed and implemented the Pulse Check, an employee satisfaction survey. The survey results showed that burnout was high. The Director explained that employees’ large caseloads due to an increasing patient population contributed to this problem, and leaders prioritized hiring in primary care to meet the demand.

## Veteran Experiences

The OIG team examined VSignals scores and found for most of FY 2025, 90 percent of veterans trusted the facility to meet their needs for outpatient care, while the VHA average was 94 percent (figure 3). The team noted that the facility shared these results with employees through the Director’s video messages and town halls, service-level meetings, and new employee orientation.



**Figure 3.** *Veteran trust in outpatient services.*  
Source: VSignals data.

In an OIG questionnaire, a patient advocate reported that delays in staff scheduling appointments were veterans' top complaints. The Director told the OIG team that scheduling delays were primarily in the community care program and could be attributed to a loss of contract schedulers in 2024.<sup>15</sup> To improve scheduling times, facility leaders ensured that administrative contact center staff received training so they could schedule appointments rather than transferring calls to other staff. These changes resulted in fewer scheduling delays and complaints from veterans.

The veteran experience officer described several programs designed to improve veterans' experiences, including placards posted throughout the facility with information on how to provide feedback. Additionally, a facility multidisciplinary group shared best customer service practices and worked to improve patient experience survey scores. For example, veterans' feedback prompted staff to implement designated quiet times on inpatient units to promote a more restful environment; they also installed individual heating and cooling units to allow patients to set comfortable temperatures for themselves.

<sup>15</sup> 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.



## ENVIRONMENT OF CARE

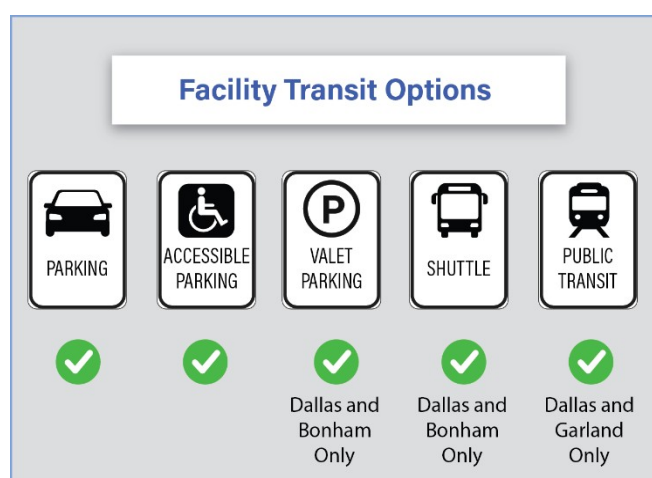
Attention to environmental design improves veterans' and staff's safety and experience.<sup>16</sup> The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, 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.<sup>17</sup>

### General Inspection

In April 2026, the OIG team physically inspected the Dallas VA Medical Center and its CLC, the Garland VA Medical Center, and the Sam Rayburn Memorial Veterans Center's CLC and outpatient clinic (in Bonham). Based on documents and observations, the team found the medical centers had well-maintained grounds and adequate parking, including accessible spots for those with disabilities. At each location, the team observed clear and easy-to-read exterior signs that directed veterans to parking areas and building entrances. The team also found the facility's navigational cues were effective for veterans with visual and hearing impairments; there were several accessibility features, including assistive technologies and trained personnel.

The Dallas VA Medical Center was generally clean. However, the OIG team observed several issues, including unlabeled patient food and damaged walls. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to ensure "a safe, clean health



**Figure 4.** Transit options for arriving at the facility.  
Source: OIG observations.

<sup>16</sup> "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

<sup>17</sup> 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.

care environment.”<sup>18</sup> Leaders submitted documents while the team was onsite that showed staff had entered repair orders and staff discarded the unlabeled patient food; therefore, the OIG did not make a recommendation.

At the Garland VA Medical Center, inspected areas were clean, but the team noted there were limited interior signs and no privacy screens at a check-in area. The operations manager explained that infrastructure and navigation projects were underway to resolve these concerns.

The OIG team observed significant infrastructure challenges at the Sam Rayburn Memorial Veterans Center related to its age, ongoing construction, and mold mitigation activities. Mold mitigation and roof repairs made it necessary for facility staff to relocate some patient care services across the hall to designated areas in the CLC. In the CLC, there were insects in exterior and interior light fixtures, missing ceiling tiles, malfunctioning lights, and floor and wall damage. Staff placed work orders for the tiles, lights, and wall during the April 2026 inspection, and they had plans to privatize patient rooms in FY 2027.

Additionally, the OIG found the CLC did not have temperature and humidity monitoring in one of the medication storage areas, as required by VHA Directive 1108.07(2), *General Pharmacy Service Requirements*.<sup>19</sup> The CLC operations manager informed the OIG team that staff monitored only the medication refrigerators and not the storage area. A facility leader told the OIG about a plan to install a monitoring system in the area, with estimated completion in August 2026; therefore, 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

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires facilities to have a written policy for the communication of test results and service-level workflows that outline team members’ roles in the process.<sup>20</sup> The directive also requires leaders to monitor communication of test results. The OIG team reviewed the facility’s policy and determined it had processes to communicate abnormal test results to providers and patients,

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<sup>18</sup> VHA Directive 1608(1).

<sup>19</sup> VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

<sup>20</sup> VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

including assigning a surrogate (substitute) when the provider who ordered the test was unavailable and ensuring staff communicated results outside regular clinic hours.<sup>21</sup> Additionally, the facility had service-level workflows that aligned with VHA Directive 1088(1).

During an interview, the Chief of Staff said staff monitor performance metrics that track the communication of test results requiring action and report the data to the Performance Measures Committee. The Chief of Staff acknowledged a period of low performance due to an unexpected staff departure, resulting in the inability to maintain a software tool the staff member had implemented to streamline the patient notification process. However, the chief stated metrics have improved since staff implemented a software program that generates letters notifying patients of their test results. The OIG noted that the facility's communication of test results metric dropped from 92 percent in quarter two of FY 2024 to 59 percent in quarter two of FY 2025. The metric then increased to 74 percent in quarter four of FY 2025, after implementation of the software program.

## Action Plans and Process Improvements

The team found no previous oversight findings or recommendations related to test result communication over the past three years. During an interview, the Chief of Staff explained that the facility uses submissions in the Joint Patient Safety Reporting system (a database used by VHA staff to report patient safety events) to identify process improvement opportunities.<sup>22</sup> Facility leaders then charter work groups to develop action plans and monitor them to completion. Executive leaders and quality management staff described several methods to convey lessons learned and new processes throughout the facility, including the shared governance program (through which unit representatives communicate initiatives and updates during staff meetings), electronic messaging, and the Director's weekly video.



VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.<sup>23</sup> 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.

<sup>21</sup> VHA Directive 1088(1); VA North Texas Health Care System MCP [medical center policy] 11-14, *Communicating Test Results to Providers and Patients*, July 11, 2024.

<sup>22</sup> VHA Directive 1050.01(1).

<sup>23</sup> "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>.

## Primary Care Staffing and Access to Care

The OIG team reviewed facility data and found vacancies for 17 providers, 13 registered nurses, 22 licensed practical nurses, and 12 medical support assistants across approximately 90 primary care teams as of April 2026. In an interview, the chief of primary care, chief nurse of primary care, and chief of healthcare administration service explained that staff departed mainly due to retirements, other job opportunities, or personal reasons. The leaders reported that vacant positions were in various phases of the hiring process, with several candidates selected, while float (cover planned and unplanned absences), fee-basis (limited service), and Veterans Integrated Service Network (VISN) Clinical Resource Hub providers maintained clinic coverage.<sup>24</sup>

In interviews, the chief of primary care, chief nurse of primary care, and primary care team members stated that staff vacancies and increased veteran enrollment contributed to larger panel sizes (number of patients assigned to a primary care team), increased workload, and longer new patient appointment wait times. The OIG team found that six primary care panels had more than 1,400 patients, which exceeds the standard of 1,200 recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.<sup>25</sup> The chief of primary care told the team there was no cap on panel sizes due to increased demand, staffing vacancies, and space limitations at some sites. The chief added that replacing a provider could take six months or more because of lengthy onboarding processes in human resources. Primary care team members shared that staff experienced burnout due to large panel sizes and coverage expectations.

The OIG team found that new patient wait times from FY 2025 through February 2026 were approximately 30 days. The chief of primary care said wait times were longer at some locations, such as the Fort Worth, Plano, and Tyler clinics, due to increased demand. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community

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<sup>24</sup> Veterans Integrated Service Networks (VISNs) are “regional care systems working together to better meet local healthcare needs and provide greater access to care.” “Veterans Integrated Service Networks,” VA, last updated July 24, 2026, <https://department.va.gov/visn>. In December 2025, VA announced plans to reorganize the management structure of VHA. 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>. “Clinical Resource Hubs (CRH),” VA, last updated March 20, 2024, <https://www.patientcare.va.gov/CRH>.

<sup>25</sup> VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

providers if the wait time is more than 20 days.<sup>26</sup> In response, the chief said staff offered veterans appointments at nearby VA clinics and through community care.

The OIG team found that wait times for primary care in the community were 59 days in FY 2025, longer than the average wait for care at the facility. The chief of primary care reported that eligible veterans often chose facility appointments because the wait times were shorter. The chief also said the Resource Management Committee had approved adding primary care teams at clinics with longer wait times and hiring additional providers across the facility to meet demand. Given the facility's plans, the OIG did not make a recommendation.

## **Community Care Staffing and Access to Care**

In an interview, the Deputy ADPCS for Outpatient, Ancillary, and Spinal Cord Injury described significant staffing challenges over the past year, including vacancies and leader departures. The OIG team reviewed facility documents showing 77 vacancies for both administrative and clinical staff at the time of the site visit in April 2026. The deputy ADPCS and chief of community care said all vacancies were in various stages of the hiring process, with several candidates selected. They also stated that insufficient staffing contributed to extensive scheduling delays and increased call center complaints about long wait times and difficulty reaching staff for assistance.

The OIG team found that in FY 2025, the top three referrals to community providers were for radiology, dental care, and home health care services. The team found it took an average of 36 days to schedule community care appointments during FY 2025, which did not meet VHA's *Consult Timeliness Standard Operating Procedure* requirement to schedule them within 7 days.<sup>27</sup> The deputy ADPCS, Associate Director for Resources, and chief of community care attributed the scheduling delays to staffing levels that were insufficient to meet the operational demand, increased referral volume, and the loss of contracted scheduling support in 2024.

The deputy ADPCS, Associate Director for Resources, and chief of community care described using overtime and dedicated time for staff to clear scheduling backlogs. The leaders said they implemented productivity standards, and supervisors monitored progress, trained staff, and streamlined work by assigning staff based on types of care. Further, the Director assigned additional executive leaders to oversee the community care program. At the time of the inspection in April 2026, the OIG team found community care scheduling had improved to 24 days. The OIG team acknowledged leaders' efforts to improve scheduling timeliness and therefore did not make a recommendation.

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<sup>26</sup> 38 C.F.R. § 17.4040 (2025).

<sup>27</sup> VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.



## VETERAN-CENTERED SAFETY NET

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.<sup>28</sup>

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).<sup>29</sup> HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff (referred to as negative exits)."<sup>30</sup>

### Performance and Improvement Highlights

- The facility's program met the permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2025 and the first quarter of FY 2026. Program staff described working with other facility staff and community partners to identify landlords and quickly find housing for veterans. The program's average time to establish housing for veterans was under 90 days.

<sup>28</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>29</sup> 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 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

<sup>30</sup> VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

- Staff said they identified veterans through outreach efforts, including five FY 2025 stand-downs (community events where veterans can get free services) that served 2,641 veterans.<sup>31</sup> Staff also identified and connected veterans to resources through the program’s walk-in clinic and Community Resource and Referral Center (which provides veterans with one-stop access to housing and health care services, career development, and VA and non-VA benefits) and a mobile medical unit that travels with program staff throughout the service area.<sup>32</sup>
- Staff also reported that the facility program opened six medical respite beds at a community assisted living facility in October 2025 for veterans who were discharged from inpatient units and needed ongoing VA follow-up care. Additionally, staff supported HCHV’s Vulnerable Veterans Program by checking on veterans during events such as severe weather to ensure they had needed resources.

## 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.”<sup>33</sup> The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.<sup>34</sup>

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).<sup>35</sup>

## Performance and Improvement Highlights

- The facility program met the voucher use (HMLS3) target for FY 2025 and the first quarter of FY 2026. Facility program staff described using surge events (when staff place veterans into available housing units), streamlining admission processes, and

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<sup>31</sup> VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

<sup>32</sup> “Community Resource and Referral Centers (CRRCs),” VA, last updated June 23, 2026, <https://department.va.gov/homeless/hchv/community-resource-and-referral-centers>.

<sup>33</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>34</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>35</sup> 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*.

working with other VA and community partners to identify new landlords willing to rent to veterans.<sup>36</sup>

- The program also met the employment (VASH3) target for FY 2025 and the first quarter of FY 2026. Staff attributed this success to ensuring accurate employment documentation in the national database and collaborating closely with employment partners. Inaccurate reporting may hinder staff's ability to identify veterans who need employment support. Employment plays a central role in helping veterans maintain stable housing, and strong collaboration with employment partners enhances the program's ability to secure and sustain meaningful job placements that support long-term housing retention.
- Staff reported working with community partners to furnish veterans' new homes and collaborating with the Veterans Benefits Administration and Social Security Administration to help veterans obtain benefits.

## 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.<sup>37</sup> 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).<sup>38</sup>

## Performance and Improvement Highlights

- The facility program met the enrollment (VJP1) target for FY 2025 and, at the time of the inspection in April 2026, was meeting the FY 2026 target. Facility program staff attributed this success to hiring two additional staff members in the fall of 2024 and conducting consistent outreach to incarcerated individuals and facility, court, jail, and prison staff.
- Staff said they collaborated with six veterans treatment courts (a court model that requires participants to complete treatment and case management services) to link veterans to mental health care, substance use disorder treatment, primary care, and

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<sup>36</sup> VA, *Home for the Holidays: A Toolkit to Support Unsheltered and Housing Surges*, October 30, 2025.

<sup>37</sup> VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

<sup>38</sup> 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*.

homeless services.<sup>39</sup> They also provided the courts with updates on treatment compliance to support positive outcomes for veterans.

- Program staff reported working with 13 prisons to assist veterans returning to the community after incarceration. At the time of the inspection in April 2026, staff were working with 5 additional prisons in other service areas to assist facilities in the VISN that are experiencing staffing vacancies.

## Conclusion

To assist leaders in evaluating the quality of care at the VA North Texas 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.

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<sup>39</sup> VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

## 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.<sup>40</sup> 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 April 7 through 9, 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.<sup>41</sup> 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*.<sup>42</sup>

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.<sup>43</sup> 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.

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<sup>40</sup> The accreditation reports covered the time frame of October 1, 2023, through September 30, 2024—the most recent available at the time of the inspection.

<sup>41</sup> Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

<sup>42</sup> 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.

<sup>43</sup> 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.<sup>44</sup> 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.

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<sup>44</sup> 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: September 28, 2026

From: Director, VA Heart of America Health Network (10N4)

Director, Health Service Area 4.3

Subj: Healthcare Facility Inspection of the VA North Texas Health Care System in Dallas

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

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA North Texas Health Care System in Dallas.
2. VISN 4 has reviewed and concurred with the recommendations made by OIG and has reviewed the response and associated plans submitted by VA North Texas Health Care System.

*(Original signed by:)*

Fernando O. Rivera, FACHE

Network Director

VA Heart of America Health Network (VISN 4), VHA

## Appendix C: Facility Director Comments

### Department of Veterans Affairs Memorandum

Date: September 1, 2026

From: Director, VA North Texas Health Care System (549)

Subj: Healthcare Facility Inspection of the VA North Texas Health Care System in Dallas

To: Director, VA Heart of America Health Network (10N4)  
Director, Health Service Area 4.3

1. We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA North Texas Health Care System in Dallas.
2. VA North Texas Health Care System notes that the OIG did not make any recommendations and has no other feedback or comments to provide at this time.

*(Original signed by:)*

Jason Cave, JD, SES  
Medical Center Director  
VA North Texas Health Care System

## OIG Contact and Staff Acknowledgments

|                           |                                                                                                                                                                                                                                                                                                                                                                                   |
|---------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
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