



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Shreveport Healthcare System in Louisiana

**Healthcare Facility
Inspection**

26-00057-170

October 2, 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 Shreveport Healthcare System (the facility) from March 23 through 26, 2026. Additionally, the OIG team contacted facility staff in June 2026 to obtain updated information and reviewed primary care patient wait time data through July 2026. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to about 39,700 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 OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG found that the facility lacked service-level workflows that outline staff roles in the process of communicating test results, and the Chief of Staff and the Associate Director for Patient Care Services did not consistently review performance data on test result communications or implement corrective actions when abnormal results were not communicated within seven days, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.³ The OIG made two associated recommendations.

¹ VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, Facility Trip Pack (VISN [Veterans Integrated Service Network] 16) Overton Brooks Veterans' Administration Medical Center, last updated January 20, 2026.

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

³ 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.⁴ 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 recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Chief of Staff and Associate Director for Patient Care Services take appropriate actions to develop written service-level workflows that describe team members' roles in the process of communicating test results, per Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
2. The Chief of Staff and Associate Director for Patient Care Services review performance measure data for test result communications and take corrective action when they identify noncompliance with communicating abnormal test results within seven days, per Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The Health Service Area 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 for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.



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⁴ 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.

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

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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.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

⁵ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

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 VA Shreveport Healthcare System (the facility) includes a medical center and three community-based outpatient clinics. In fiscal year (FY) 2025, the medical care budget was approximately \$690 million; the facility had 77 beds and served about 39,700 veterans.

The OIG team inspected the facility from March 23 through 26, 2026; contacted facility staff in June 2026 for updates; and reviewed primary care wait time data through July 2026. The executive leaders referred to throughout this report include the Director, Chief of Staff, Associate Director, Assistant Director, and Associate Director for Patient Care Services.



Figure 1. Facility photo.

Source: Photo taken by OIG inspector.



CULTURE

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

System Shocks

Executive leaders described a January 2026 ice storm, which immobilized the city and halted normal facility operations for several days, as a system shock. The leaders emphasized that two priorities guided decision-making during the event: maintaining high-quality care for veterans and protecting the safety of employees.

The Associate Director for Patient Care Services reported that executive leaders activated emergency management processes several days in advance of the storm, conducted planning

¹⁰ Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, <https://doi.org/10.1136/bmjqs-2017-007573>.

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

¹² Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, <https://www.va.gov/patientadvocate>. For more information on the OIG's data collection methods, see appendix A.

meetings, and communicated contingency plans through employee town halls. The Chief of Staff stated that inpatient care continued uninterrupted, and employees rescheduled outpatient appointments or converted them to virtual visits, with no adverse patient safety events. The Associate Director further explained that many employees stayed on-site for several days; they had access to available inpatient rooms for resting, cots for sleeping, clean linen supplies, reliable meal service, and chaplain support activities. The emergency manager, responsible for the facility's emergency preparedness and disaster response, also remained at the facility to coordinate employee needs in real time. The Chief of Staff reported that executive leaders approved telework for employees who were not involved in direct patient care to maintain facility operations.

To communicate with veterans and other stakeholders, executive leaders said they used emails, local news stations, and social media; they also informed patients of appointment changes through text notifications. Facility employees proactively contacted veterans who received dialysis or chemotherapy to ensure these individuals obtained needed support. Nursing service employees also contacted family members of inpatients to explain safety risks and the possibility that visitors to the medical center might be unable to leave due to weather conditions.

The Director explained that following the ice storm, executive leaders reviewed the facility's emergency response to identify opportunities for improvement. The Director said the review confirmed that inpatient care remained safe but revealed communication gaps with external partners, including on-site credit union employees, contract personnel, and medical residents (physicians in training), who did not receive timely notification prior to the impending facility shutdown. The Associate Director stated that executive leaders applied lessons learned from the review by adding the groups to the email contact list, which improved communication during a subsequent citywide water outage.

Employee Experiences

Responses to the OIG questionnaire indicated that employees generally feel comfortable reporting safety concerns and suggesting actions to improve their work environment. Over half of the respondents identified caring for veterans and the pay and benefits as top reasons they keep working at the facility. However, roughly one third of the respondents also expressed that stress and burnout made them consider leaving the facility.

Executive leaders communicated and showed their support through walks around the medical center and visits to the community-based outpatient clinics to talk with employees; weekly town halls, featuring a series that highlighted leaders' backgrounds and experiences; and daily tiered huddles (a series of meetings with employees and leaders at various levels).

Veteran Experiences

Patient advocates said that veterans’ most frequently expressed concerns were about primary care—specifically, provider turnover and requests to change providers. Executive leaders reported the facility’s FY 2025 VSignals score for outpatient services was 90 percent, below VHA’s average of 94 percent, which they attributed to dissatisfaction with provider turnover and preferences for in-person care over telehealth appointments. The Chief of Staff stated that multiple facility providers retired, contributing to staffing gaps in primary care. To address staffing losses, the Associate Director and Chief of Staff increased efforts to recruit and hire new providers.



Attention to environmental design improves veterans’ and staff’s safety and experience.¹³ 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.¹⁴

General Inspection

The OIG team easily navigated to the facility. Inspectors noted clear directional signs, accessible spaces in the parking garage and surrounding lots, and bus stops nearby for public transportation.

The main entrance included a covered area for passenger loading and unloading, power-assisted sliding doors, and available wheelchairs. The entrance was welcoming,

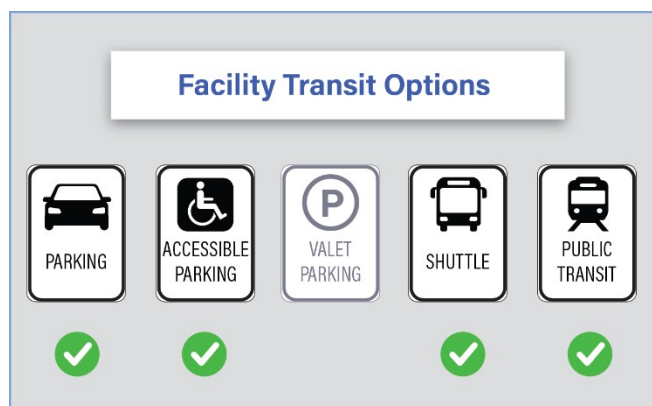


Figure 2. Transit options for arriving at the facility.
Source: Inspector observations, facility liaison questionnaire, and parking map.

¹³ “Informing Healing Spaces through Environmental Design: Thirteen Tips,” VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

¹⁴ 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.

with natural light and ample seating. Volunteers at the information desk greeted veterans, answered questions, and assisted with navigation. The volunteers said they communicate with hearing-impaired individuals by using written instructions, and escort those with visual impairments to appointments. Facility leaders confirmed that staff have access to translation services when needed.

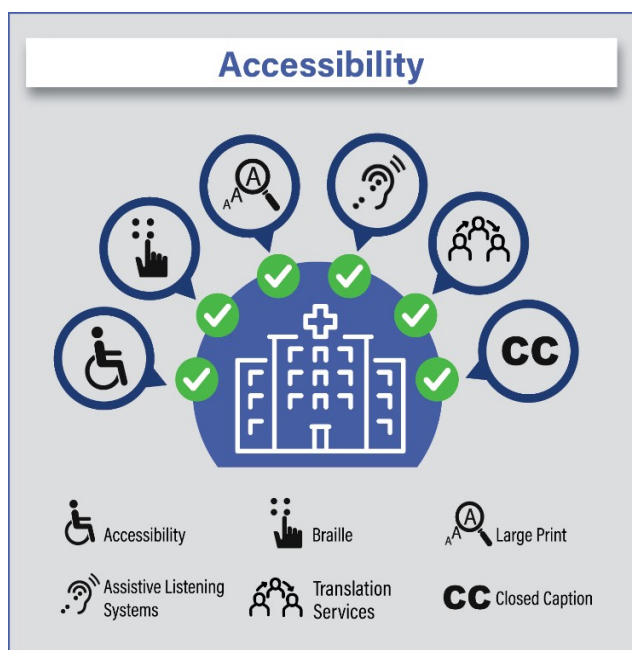


Figure 3. Accessibility tools available to veterans with impairments.

Source: Inspector observations, facility liaison questionnaire response, and parking map.

chief reported that staff had installed privacy protector screens, so the OIG did not make a recommendation.

The OIG inspectors observed color-coded maps and directories on each floor, and signs throughout the facility that supported navigation to clinical and nonclinical areas. The inspectors also noted large-print signs, braille on room placards and elevators, and audio cues in elevators.

The team inspected primary care and women's health clinics, the medical-surgical and intensive care units, and the emergency department. The areas were generally clean and well-maintained, with no significant safety or security issues identified.

However, the OIG inspectors also observed staff using computers in emergency department hallways where patients' information was visible to individuals walking by. On April 16, 2026, about three weeks after the inspection, the emergency department



PATIENT SAFETY

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* required facilities to develop a policy and service-level workflows for communicating test results.¹⁵ The OIG team found that executive leaders developed a local policy; however, they did not create service-level workflows that define team members' roles in the communication process.¹⁶ When staff lack defined workflows, they may not understand their responsibilities to communicate test results, leading to inconsistent practices and delays in patient notification and follow-up care.

Recommendation 1

The Chief of Staff and Associate Director for Patient Care Services take appropriate actions to develop written service-level workflows that describe team members' roles in the process of communicating test results, per Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: October 31, 2026

Director Comments

As of September 8, 2026, the Chief of Staff and Associate Director for Patient Care Services have developed service-level workflows that describe team members' roles in the process of communicating test results. Education will commence September 14, 2026, for all appropriate staff per Service Level workflow. Compliance with training will be reported in Quality & Patient Safety Board.

The target measure for education is $\geq 90\%$.

¹⁵ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

¹⁶ Overton Brooks VA Medical Center Policy 11-24, *Communicating Test Results to Providers and Patients*, October 29, 2024.

The Chief of Staff and Associate Director for Patient Care Services must review data on test result communications and take corrective action when they identify noncompliance with staff communicating abnormal test results requiring action within seven days, in accordance with VHA Directive 1088(1).¹⁷ The OIG reviewed External Peer Review Program data and found that performance for provider-to-patient test result communications declined from 86 percent in the first quarter of FY 2025 to 69 percent in the fourth quarter of FY 2025.¹⁸

At the time of the inspection in March 2026, the Chief of Staff reported that ongoing professional performance evaluations (a quality review of providers' ability to provide safe care) and patient safety reports also identified gaps in provider-to-patient communication.¹⁹ Leaders formed a workgroup and created an action plan in May 2025 to improve provider-to-patient communications. However, the Chief of Staff noted that the Strategic Analytics for Improvement and Learning Committee had minimally tracked the workgroup's progress due to competing priorities. Additionally, the Chief of Staff and the chief of quality management said they reviewed data on test result communications only in July 2024 and January 2026 because they were focused on other declining quality metrics.

When the Associate Director for Patient Care Services and Chief of Staff do not consistently review and act on test result communication data, they may overlook persistently declining provider performance, which increases the risk of delayed or missed follow-up care for patients. The OIG team requested an update in June 2026 and found that, although quality management staff had begun reporting data and action plans to the Strategic Analytics for Improvement and Learning Committee, performance still declined to about 66 percent in the second quarter of FY 2026.

Recommendation 2

The Chief of Staff and Associate Director for Patient Care Services review performance measure data for test result communications and take corrective action when they identify noncompliance with communicating abnormal test results within seven days, per Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

 X Concur

 Nonconcur

¹⁷ Overton Brooks VA Medical Center Policy 11-24, *Communicating Test Results to Providers and Patients*.

¹⁸ VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

¹⁹ VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

Target date for completion: April 30, 2027

Director Comments

On April 14, 2026, Chief of Staff and Associate Director of Patient Care Services implemented a process to proactively review the laboratory tests in the ctr24 measure. This process includes obtaining a list of these abnormal test results from the previous day. Quality & Patient Safety staff notify the ordering provider via Microsoft Teams of the abnormal test result requiring action with a reminder to notify the Veteran within 7 calendar days and document the communication. Follow-up is completed several times within the 7-day timeframe with additional reminders sent as needed. If there is no notification of the test result timely, the information is escalated to the appropriate supervisor. Monthly retrospective audits are conducted by Quality & Patient Safety staff for abnormal laboratory and radiology results requiring action. This data is being reported monthly during the Quality & Patient Safety Board.

The Chief of Quality and Patient Safety or Designee will provide monthly reports to the Chief of Staff and Associate Director for Patient Care Services for non-compliance with communication of abnormal test results. Chief of Staff or Associate Director of Patient Care Services will take corrective action as deemed appropriate.

Random monthly audits will be conducted with a minimum of 30 abnormal test results. The target measure for compliance with communicating abnormal test results requiring action is $\geq 90\%$ for 2 consecutive quarters.

Action Plans and Process Improvements

The facility had resolved all findings from the previous OIG comprehensive healthcare inspection report, published in November 2023.²⁰ The accreditation specialist said they track action plans with a spreadsheet, through workgroups, and through the Quality Patient Safety Board.

However, the OIG team reviewed staff-reported safety events from the 12 months preceding the March 2026 inspection and identified a recurring pattern of mislabeled specimens. The patient safety manager reported completing a risk assessment and noted improvements after educating staff. The patient safety manager added that a contract for a new labeling machine was complete and, once installed, will also help improve the process for labeling specimens.

²⁰ VA OIG, [*Comprehensive Healthcare Inspection of the Overton Brooks VA Medical Center in Shreveport, Louisiana*](#), Report No. 22-00240-17, November 15, 2023.



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.²¹ 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

Primary care leaders shared documents in March and April 2026 that showed vacancies for primary care providers, a registered nurse, licensed practical nurses, and medical support assistants. A primary care staff member reported that vacant provider positions caused some patient panels (patients assigned to a primary care team) to exceed the intended size as referenced in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*.²² The staff member added that, although 45 percent of panels were over capacity, patients still receive needed care, and staff prioritize urgent cases. The staff member also said the facility uses Veterans Integrated Service Network (VISN) resource providers (who help serve areas experiencing gaps in access to care) or manages coverage internally with assistance from other providers within the facility.²³

According to primary care leaders and a staff member, recruitment is difficult and some candidates choose other jobs because the hiring process takes too long. Leaders described a multiple-step process to hire, including market pay reviews (a comparison of other healthcare employers' pay scales), background checks, and credentialing (verifying experience and licensing), which can take several weeks or months. A provider said they had recently retired

²¹ "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.

²² VHA sets a baseline capacity of 1,200 patients for physicians and 900 for nonphysician providers. VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

²³ VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "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>.

from the facility and then decided to return but had to wait five months despite having an active license to practice and relevant experience. Staff added that vacancies mean fewer staff are available to respond to online messages from patients and internal alerts from other departments.

The Code of Federal Regulations, title 38, section 17.4040 states that patients may be referred to community providers if the wait time is over 20 days.²⁴ In FY 2025, the facility's primary care appointment wait times for new patients averaged 35 days, but by July 2026, the average decreased to 19 days. Primary care leaders attributed this improvement to initiatives such as regularly reviewing team panels, scheduling other veterans into appointment times that are open due to cancellations, and offering Saturday clinics.

On April 9, 2026, the wait times for primary care at the clinics in Texarkana and Longview, Texas, and Monroe, Louisiana, averaged 28, 30, and 31 days, respectively. Primary care leaders explained they are recruiting additional providers to these clinics because panel sizes are over capacity and patient requests to receive their care at these sites have increased.

Community Care Staffing and Access to Care

Prior to the inspection, a community care leader shared documents that showed community care staff vacancies for registered nurses, a licensed practical nurse, and medical support assistants; recruitment for these positions was at various stages. The community care leader expressed concern that new hires only replace departing staff rather than increase staffing, and community care referral volumes continue to rise.

The facility's community care department received more than 75,000 referrals in FY 2025, up by 11,000 from the previous year. Community care leaders attributed the increase to insufficient numbers of facility specialty care providers, such as gastroenterologists (specialists in the digestive system), urologists (specialists in the urinary system), and nephrologists (specialists in treating kidney conditions). The Chief of Staff and primary care leaders reported efforts to secure a contract with local gastroenterology providers to help with coverage and to recruit other specialty care providers.

Community care staff scheduled appointments in an average of 15 days during FY 2025, which was longer than the 7-day guideline in VHA's *Consult Timeliness Standard Operating Procedure*.²⁵ Staff said scheduling is often delayed by slow community provider responses and limited availability, with some specialists accepting only a few VA patients each month.

When asked about process improvements, a community care leader described a project in which automation software, installed in February 2026, sends medical record requests for all completed

²⁴ 38 C.F.R. § 17.4040 (2025).

²⁵ VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," last updated June 12, 2025.

appointments to community providers. The leader said the software automates the process of sending records requests to community care providers for completed appointments, allowing the team to confirm appointment attendance and obtain records. The leader added that the number of pending record requests dropped from about 8,500 to 4,600, and workflow efficiency had improved.



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.²⁶

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).²⁷ 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).”²⁸

²⁶ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

²⁷ 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.

²⁸ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

Performance and Improvement Highlights

- The facility program met the permanent housing (HCHV1) target for FY 2025 and the first quarter of FY 2026, but not for the second quarter. The HCHV coordinator explained that for several unplanned exits that occurred in March 2026, the veterans' housing status at discharge was unknown, which negatively affected the metric. The coordinator said staff plan to help contracted emergency residential services strengthen intake screens to identify veterans who are at risk for early program departures.
- Facility program staff added their initial success was due to effective partnerships with Supportive Services for Veteran Families (which uses private or nonprofit grants to support very low-income families who are in or transitioning to permanent housing), contracted residential services, and community agencies, as well as long-standing relationships with local landlords.²⁹ Program staff also attributed meeting the target to a local police officer who helps veterans obtain identification cards needed for placement into housing or shelters.
- The facility program did not meet the negative exits (HCHV2) target during FY 2025 or the first two quarters of FY 2026. The coordinator said staff worked with contractors to manage problematic behaviors and clarify program expectations with veterans to prevent repeated rule violations that could lead to discharge.

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.”³⁰ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.³¹

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).³²

²⁹ VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

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

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

³² 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*.

Performance and Improvement Highlights

- The assistant homeless program manager said the facility program had 398 vouchers, and staff worked with nine public housing agencies across Louisiana as well as in Arkansas and Texas. The facility program met the voucher use (HMLS3) target for the first two quarters of FY 2026. Program staff attributed this success to outreach in rural locations where veterans can complete a preliminary assessment to determine program eligibility. A facility program social worker said staff review referrals weekly to identify veterans who are likely to enter the program; then they try to connect the veterans with a housing agency the same week to begin the voucher process.
- Staff said success means more than meeting metrics; it occurs when a veteran enters the program and subsequently lives independently with needed support. The peer support specialist discussed advancing from a program participant to a peer support specialist and then becoming the VISN's peer specialist subject matter expert. The specialist added that mentorship through the program has helped support veterans who faced similar challenges.
- The facility program met the employment (VASH3) target in FY 2025 and the first two quarters of FY 2026. Staff credited this to the vocational development specialists who help veterans write résumés, navigate Social Security processes, and connect with potential employers and job fairs. The HUD-VASH assistant program manager said veterans also receive VA services, such as mental health care, to help stabilize various aspects of their lives.

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.³³ 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).³⁴

³³ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

³⁴ 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*.

Performance and Improvement Highlights

- Facility program staff met the enrollment (VJP1) target for FY 2025 and the first two quarters of FY 2026. The homeless program manager credited this to program outreach specialists who cover 36 jails and prisons in three states and more than 32 counties and parishes. One of the outreach specialists said referrals increased after they met with employees at local jails, law enforcement agencies, probation and parole offices, religious groups, and community providers.
- The homeless program manager said one veteran treatment court (a supervised program that provides coordinated treatment for veterans instead of traditional sentencing) currently serves two of the largest counties in the service area.³⁵ Facility program staff continue their efforts to establish a second court in Monroe and collaborate with existing drug courts, so veterans do not have to travel long distances to attend.

Staff noted that one jail improved veteran identification by changing its intake question from "Are you a veteran?" to "Have you served in the military?" The employees told program staff that some individuals with prior military service do not identify as veterans, such as those without combat experience. The outreach specialists said they plan to help more jails adopt the revised question.

Figure 4. Highlighted information related to the Veterans Justice Program. Source: OIG analysis of documents and interviews.

Conclusion

To assist leaders in evaluating the quality of care at the VA Shreveport Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to test result communications. 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.

³⁵ 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.³⁶ 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 March 23 through 26, 2026; contacted facility staff in June 2026 for updates; and reviewed primary care patient wait time data through July 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.³⁷ 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*.³⁸

Possible limitations on the information collection methods include questionnaire and interview participants’ self-selection bias and response bias.³⁹ The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked

³⁶ The accreditation reports covered the time frame of October 1, 2022, through September 30, 2025—the most recent available at the time of the inspection.

³⁷ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

³⁸ 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.

³⁹ 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>.

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 1978.⁴⁰ 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.

⁴⁰ Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 17, 2026

From: Executive Director, Health Service Area 4.1

Subj: Healthcare Facility Inspection of the VA Shreveport Healthcare System in Louisiana

To: Director, Office of Healthcare Inspections (54HF05)
Chief Integrity and Compliance Officer (10OIC)

The Health Service Area 4.1 has reviewed and concurs with the findings, recommendations, and submitted action plan for the Healthcare Facility Inspection of the VA Shreveport Healthcare System in Louisiana.

(Original signed by:)

Stephanie A. Repasky, Psy.D.

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 11, 2026

From: Director, VA Shreveport Healthcare System (667)

Subj: Healthcare Facility Inspection of the VA Shreveport Healthcare System in Louisiana

To: Director, VA Heart of America Health Network (10N4)
Director, Health Service Area 4.1

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the VA Shreveport Healthcare System in Louisiana.
2. I have reviewed the draft report and concur with the recommendations, noting the thorough evaluation by the OIG.
3. For questions regarding information provided, please contact the Chief, Quality & Patient Safety.

(Original signed by:)

Richard L. Crockett

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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.