



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA West Texas Healthcare System in Big Spring

**Healthcare Facility
Inspection**

26-00040-285

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 West Texas Healthcare System (the facility) from February 17 through 23, 2026, and facility leaders provided an update in June 2026. The facility is rated as *low complexity* and in fiscal year 2025, provided direct care to about 20,700 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 found issues with the facility's water testing program and made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG team found that the facility did not have a policy or service-level workflows for the communication of test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.³ Additionally, staff did not consistently notify patients about abnormal results for prostate-specific antigen tests (which are used to diagnose prostate cancer) within seven days, as required by VHA Directive 1088(1). Leaders also relied on email voting instead of holding in-person or virtual committee meetings. The Joint Commission standards MS [Medical Staff] 16.01.01 and LD [Leadership] 11.01.01 include expectations for medical staff representation at governing body

¹ VHA classifies facilities based on their complexity level. Low-complexity facilities have "low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through May," VHA Support Service Center, last updated June 1, 2026, <https://reports.vssc.med.va.gov/OperationalStatisticsTable>. (This web page is not publicly accessible.)

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.

meetings, as well as physician leadership and oversight related to patient safety and satisfaction.⁴ The OIG made four recommendations.

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

What the OIG Recommended

1. The Director takes appropriate actions so that staff consistently follow the facility's *Legionella* prevention plan and achieve and sustain compliance with all applicable requirements in Veterans Health Administration Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems* to prevent contamination and maintain water quality, including testing, documentation, and mitigation actions, to protect resident safety in the community living center.⁶
2. The Director develops and implements a written policy for communicating test results that aligns with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
3. The Chief of Staff and Associate Director for Patient Care Services develop written service-level workflows that align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.
4. The Chief of Staff and Associate Director for Patient Care Services take corrective actions to address unfavorable trends in the communication of test results in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

⁴ The Joint Commission, *Standards Manual*, E-dition, MS 16.01.01 and LD 11.01.01, March 1, 2026.

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

⁶ VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, February 16, 2021, amended October 21, 2024.

5. The Director evaluates the Healthcare Delivery Board and takes actions when warranted to provide proper oversight of clinical care quality in accordance with Joint Commission standards Medical Staff 16.01.01 and Leadership 11.01.01.⁷

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). Based on information provided, the OIG considers recommendation 5 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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⁷ The Joint Commission, *Standards Manual*, E-dition, MS 16.01.01 and LD 11.01.01, March 1, 2026.

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.⁸ 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.⁹



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.¹⁰



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.¹¹



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.¹²

⁸ "About Us," VA, last updated June 2, 2026, <https://department.va.gov/vha/about-us>.

⁹ 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>.

¹⁰ VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

¹¹ VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

¹² VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

The VA West Texas Healthcare System (the facility) includes the George H. O'Brien, Jr., VA Medical Center in Big Spring, which was built in 1950, and several community-based outpatient clinics in west Texas and New Mexico.¹³ The facility's budget for fiscal year (FY) 2025 was approximately \$401 million.¹⁴ It has 40 community living center and 40 domiciliary beds.¹⁵ However, the Associate Director for Patient Care Services said that, due to staffing vacancies, executive leaders received Veterans Integrated Service Network (VISN) approval in September 2025 to temporarily reduce the total capacity of the domiciliary to 12 beds.¹⁶ In a June 2026 update, the chief of quality and patient safety informed the OIG team that the domiciliary capacity remained unchanged because vacancies persisted.



Figure 1. Facility photo.

Source: "George H. O'Brien, Jr., Department of Veterans Affairs Medical Center," VA, last updated February 14, 2024, <https://www.va.gov/west-texas-health-care>.

The OIG team inspected the facility from February 17 through 23, 2026 and facility leaders provided an update in June 2026. The facility's executive leaders referred to throughout this report include the Acting Director, who was also the permanent Associate Director; the Chief of Staff; the Associate Director for Patient Care Services; and the Assistant Director. These leaders all started between August 2023 and June 2024, and the Associate Director had covered both the acting director and associate director roles since January 12, 2026.

¹³ The locations are Abilene, San Angelo, Odessa, and Fort Stockton, Texas, and Hobbs, New Mexico.

¹⁴ "Trip Pack - Operational Statistics Table FY2026 Through May," VHA Support Service Center, last updated June 1, 2026, <https://reports.vssc.med.va.gov/OperationalStatisticsTable>. (This web page is not publicly accessible.)

¹⁵ A community living center is also known as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. 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>.

¹⁶ 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>.



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.¹⁷ 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).¹⁸ The team also interviewed executive and facility leaders and employees and considered data from patient advocates.

System Shocks

During an OIG interview, the executive leaders identified two system shocks. Most recently, a winter storm in January 2026 disrupted operations. Leaders activated the emergency response plan, met with employees before the storm, and assigned some staff to overnight areas to remain on-site to maintain operations. They also communicated with employees through automated messages and with veterans through social media. The Associate Director for Patient Care Services said nurses called vulnerable veterans to confirm their safety and determine what resources they needed.

The Acting Director stated the storm caused reduced operations for several days. The Associate Director for Patient Care Services explained that prior to the storm, nurses and administrative employees worked together to reschedule patients, and one primary care team stayed late to accommodate veterans.

Executive leaders also described administrative disruptions from the hiring freeze (in effect from January 20, 2025, to October 15, 2025) and deferred resignation program.¹⁹ They stated that

¹⁷ 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>.

¹⁸ "Veteran Trust in VA," VA, last updated June 4, 2026, <https://www.va.gov/initiatives/veteran-trust-in-va>.

¹⁹ Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025. VHA placed full-time employees who accepted the deferred resignation program into paid administrative leave until September 30, 2025, unless they were eligible to retire earlier. Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025, <https://www.opm.gov/fork/original-email-to-employees>.

hiring restrictions negatively affected the facility because leaders could not replace employees who left the organization, which contributed to increased workloads and fatigue among remaining employees. Leaders also reported difficulty recruiting new employees because many candidates hesitated to pursue federal employment. To reinforce the facility’s mission and dispel rumors, the Acting Director said executive leaders maintained transparency through frequent employee communications. The Associate Director for Patient Care Services added that executive leaders made frequent rounds (visits to work areas) to answer questions and support employees.

Employee Experiences

Since VA did not administer the All Employee Survey in FY 2025, the OIG team inquired how leaders assessed employee engagement and satisfaction.²⁰ In addition to rounds, the Acting Director said executive leaders communicate and receive employee feedback through daily huddles (meetings), town halls, new employee orientation, and exit surveys, and noted that employees appreciate their leaders’ engagement and transparency. The Acting Director also said they changed the frequency of town halls from twice a month to weekly based on employee feedback. The responses shown in figure 2 indicate that more than half of respondents to the OIG questionnaire are comfortable suggesting actions to improve the work environment.

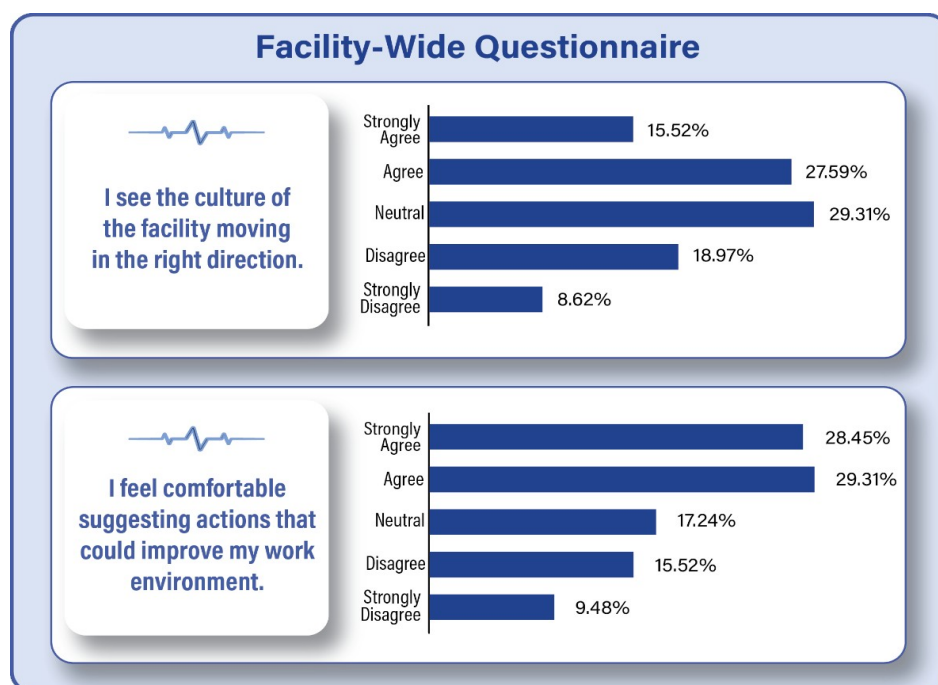


Figure 2. Employee perceptions of facility culture.

Source: OIG analysis of selected questionnaire responses.

²⁰ The All Employee Survey is an annual, voluntary survey of VA workforce experiences. “AES Survey History, Understanding Workplace Experiences in VA,” VHA National Center for Organization Development.

Veteran Experiences

In the OIG questionnaire, most patient advocates indicated that leaders are responsive to veterans' concerns and resolve them effectively. However, respondents identified lengthy community care processes as a common concern.²¹ The Assistant Director explained that veterans travel to other cities for needed care because of limited numbers of specialty care providers in the facility's rural location.

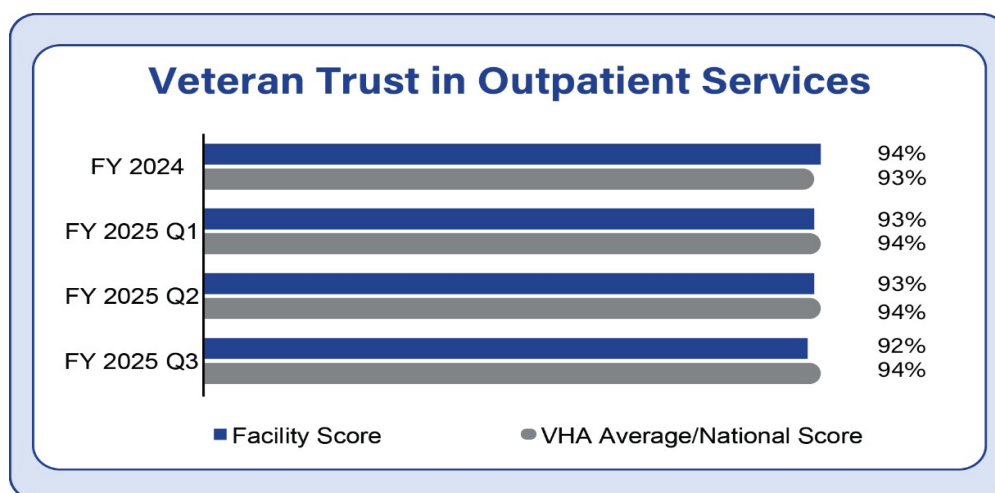


Figure 3. Veteran trust in outpatient services.

Source: VSignals data.

The OIG team noted VSignals scores were higher than VHA averages in FY 2024 and slightly decreased through the third quarter of FY 2025, as shown in figure 3. The Acting Director attributed the decline to clinical staff turnover. To improve veteran satisfaction, leaders said they took several actions such as contacting service chiefs and veterans directly to ensure staff addressed issues. To further improve veterans' experiences, the Chief of Staff described a practice intended to reinforce to veterans that providers hear their concerns; this involves active listening during each appointment, making eye contact with the veteran, and not shifting focus to other activities, such as using the computer.

²¹ 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.²² 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.²³

General Inspection

An OIG inspector observed parking near the front entrance, but some accessible spaces for those with disabilities were missing required signs, and others had faded pavement markings. The *VA Signage PG-18-10, Design Manual* requires these parking spaces to display signs with the international symbol of accessibility (a stylized figure seated in a wheelchair), and the *Guide to the ABA Accessibility Standards* requires a marked parking space and access aisle.²⁴

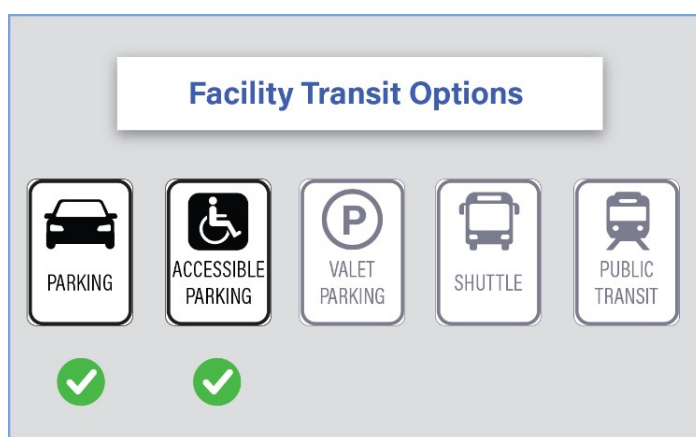


Figure 4. Transit options for arriving at the facility.
Source: Facility parking lot maps and an OIG questionnaire response.

In addition, multiple crosswalks lacked detectible warning surfaces, which the *VA Site PG-18-10, Design Manual* requires to alert visually impaired pedestrians of potential hazards before they transition onto a roadway.²⁵ The OIG inspector learned that facility leaders knew about these problems, started a design project to correct them, and expected the work to begin in FY 2028. Therefore, the OIG did not make a recommendation.

²² "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, <https://www.va.gov/WholeHealth/Healing-Spaces>.

²³ 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.

²⁴ "Guide to the ABA Accessibility Standards," Access Board, accessed February 24, 2026, <https://www.access-board.gov/aba/guides/chapter-5-parking>.

²⁵ VA, *VA Site PG 18-10, Design Manual*, February 1, 2013, revised March 1, 2024.

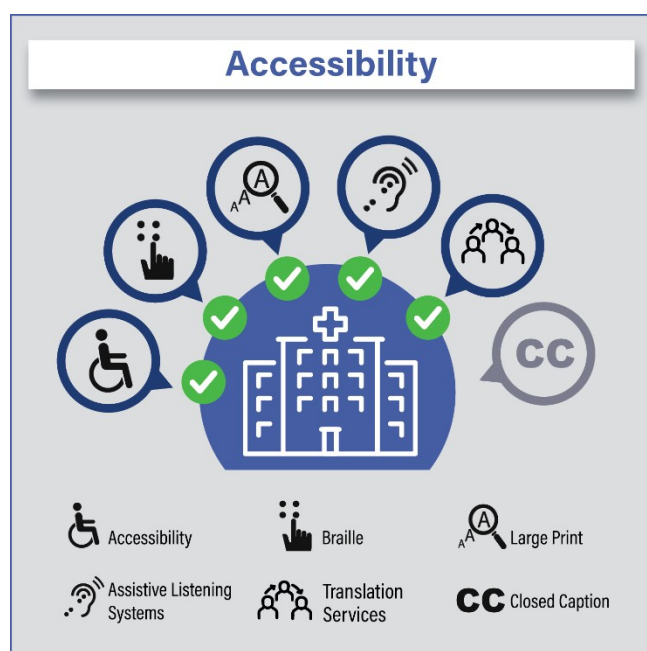


Figure 5. Accessibility tools available to veterans with impairments.

Source: Observations and an OIG questionnaire response.

The main entrance appeared generally clean, and multiple features were available to aid veterans with impairments (see figure 5). There were directional signs on the walls, but they did not identify the community living center; a facility leader said this was an oversight they would correct.

The inspector also identified safety concerns, including holes in several ceiling tiles, which could allow dust, debris, and contaminants to enter the space and increase infection risks for veterans and staff. Facility leaders explained the holes were left when staff relocated televisions. The leaders subsequently provided documents during the on-site inspection showing staff had fixed the holes, so the OIG did not make a recommendation.

Additionally, stickers affixed to medical equipment showed scheduled maintenance, but some items were overdue. The Joint Commission standard EC [Environment of Care] 02.04.03 requires staff to inspect, test, and maintain all medical equipment and document these activities.²⁶ If staff do not regularly maintain medical equipment, it may malfunction during use. The Associate Director explained that staff had not yet added some equipment to the new tracking program. Because of the OIG findings, staff corrected the tracking program's equipment list but had not completed the missed preventive maintenance during the February 2026 OIG site visit. In June 2026, a facility leader provided documents showing that staff had inspected the equipment, so OIG did not make a recommendation.

The OIG inspector also found the facility did not consistently follow its prevention plan for *Legionella* (a waterborne bacteria spread through building water systems that can cause severe illness, especially for people with weak immune systems) in the community living center. VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, requires facilities to have a *Legionella* prevention plan, and the director must ensure staff implement preventive measures.²⁷ Although the facility's plan identifies the

²⁶ The Joint Commission, *Standards Manual*, E-dition, EC.02.04.03, January 1, 2026; According to VHA Directive 1860, VHA is to follow Joint Commission standards. VHA Directive 1860, *Healthcare Technology Management Performance Monitoring and Improvement*, August 19, 2024.

²⁷ VHA Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems*, February 16, 2021, amended October 21, 2024.

community living center as a high-risk area and outlines required mitigation steps, such as twice weekly fixture flushing, the inspector could not confirm whether staff carried out these actions.

Facility staff provided evidence of routine testing in the community living center for one communal shower and some sinks, which showed persistent positive *Legionella* results over several months. To mitigate risks to residents, staff reported they use the communal shower, which has a filter that blocks bacteria. However, Water Safety Committee meeting minutes did not clearly indicate the facility's response to the repeated positive results. These issues created uncertainty about whether staff were implementing the facility's risk mitigation strategies as intended for this medically vulnerable population.

Recommendation 1

The Director takes appropriate actions so that staff consistently follow the facility's *Legionella* prevention plan and achieve and sustain compliance with all applicable requirements in Veterans Health Administration Directive 1061(4), *Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems* to prevent contamination and maintain water quality, including testing, documentation, and mitigation actions, to protect resident safety in the community living center.

☒ Concur

☐ Nonconcur

Target date for completion: June 30, 2027

Director Comments

The facility previously established a Water Tiger Team which had implemented twice weekly flushing of water fixtures in patient care areas and low use areas and created a draft facility *Legionella* prevention plan and working to finalize. The facility will continue with quarterly legionella testing and will report results and remediation efforts through the Water Safety Committee. The facility will flush patient care areas and low use fixtures twice weekly with a goal of 90% compliance of dates flushed in patient care areas and report in the Water Safety Committee.



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

The facility did not have a policy for communicating test results, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.²⁸ Additionally, the facility did not have required service-level workflows that outline staff roles in the process, though they did have nursing protocols for test result communications. Established facility systems for communicating test results are essential for keeping patients informed and making sure they receive timely, appropriate care.

The OIG team is concerned that executive leaders took no action to comply with VHA requirements, despite multiple opportunities. Missed opportunities include the following:

- On July 11, 2023, VHA published the directive, with a 6- to 12-month requirement to develop a local policy and service-level workflows.²⁹
- On September 20, 2024, VHA amended the directive, which further clarified expectations for service-level workflows.³⁰
- Prior to the site visit, the OIG published several reports with findings and recommendations related to facilities' lack of policies and procedures that comply with the directive.³¹
- In December 2025, the OIG team requested facility policies and service-level workflows related to test result communication.

At the time of the February 2026 inspection, the facility provided the OIG with a draft policy dated February 1, 2026, and one undated draft service-level workflow for communication of test results to patients. The OIG team reviewed the service-level workflow and nursing protocols and

²⁸ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

²⁹ VHA Directive 1088(1).

³⁰ VHA Directive 1088(1).

³¹ Examples are VA OIG, [Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia](#), Report No. 24-00592-60, March 6, 2025; VA OIG, [Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia](#), Report No. 24-00603-86, March 26, 2025; VA OIG, [Healthcare Facility Inspection of the VA Louisville Healthcare System in Kentucky](#), Report No. 24-03205-235, October 17, 2025; and VA OIG, [Healthcare Facility Inspection of the Sheridan VA Health Care System in Wyoming](#), Report No. 24-00615-163, July 10, 2025.

found the workflow contradicted the nursing protocols. The workflow said registered nurses cannot communicate test results unless delegated by a provider; however, the protocols stated registered nurses and licensed vocational nurses can notify patients of normal test results but require provider input for abnormal results. The Chief of Staff said the prior policy lacked certain directive requirements, such as workflows, so staff were revising it.

Recommendation 2

The Director develops and implements a written policy for communicating test results that aligns with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: March 31, 2027

Director Comments

The VA West Texas Healthcare System plans to revise, update, and implement the medical center policy to align with VHA Directive 1088(1).

Recommendation 3

The Chief of Staff and Associate Director for Patient Care Services develop written service-level workflows that align with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: March 31, 2027

Director Comments

The VA West Texas Healthcare System plans to revise, update, and implement service level workflows to align with local medical center policy and VHA Directive 1088(1).

The OIG team also reviewed the facility's FY 2025 audits of prostate-specific antigen results (a test used in the diagnosis of prostate cancer) completed by quality and patient safety staff at the VISN's request. Based on the results, staff notified patients of abnormal results within seven

days, as required by VHA Directive 1088(1), approximately 60 percent of the time.³² When staff do not relay results promptly, they may miss important health conditions. Leaders acknowledged the issue and reported that facility staff implemented changes to the notification process in July 2025. Despite the updated process, the OIG found their compliance with the notification requirement for prostate-specific antigen results had decreased to 55 percent in the first quarter of FY 2026.

Recommendation 4

The Chief of Staff and Associate Director for Patient Care Services take corrective actions to address unfavorable trends in the communication of test results in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

☒ Concur

☐ Nonconcur

Target date for completion: June 30, 2027

Director Comments

The facility has developed and implemented two corrective action plans to address unfavorable trends in test result communication, in alignment with VHA Directive 1088(1). These corrective action plans include provider education on critical laboratory and abnormal Prostate-Specific Antigen (PSA) related result notification requirements; optimization of laboratory documentation workflows by Health Information Management; monthly chart audits of critical laboratory results and PSA related communication; quarterly trend reviews to identify providers who require targeted re education; and oversight of audit outcomes through monthly leadership review and quarterly reporting to the Healthcare Delivery Board. The facility will monitor compliance until at least 90 percent adherence for critical laboratory communication and adherence for abnormal PSA result communication is maintained for six consecutive months.

³² Merriam-Webster, "Prostate-Specific Antigen," last updated March 21, 2026, <https://www.merriam-webster.com/prostatespecificantigen>.

Action Plans and Process Improvements

The OIG reviewed the prior OIG Comprehensive Healthcare Inspection Program report (May 2023) and the Joint Commission survey report (February 2024) and found no open (unimplemented) recommendations.³³ The chief of quality and patient safety explained that staff identify process improvement projects through reviews of facility metrics and employee suggestions. The chief health informatics officer added that staff share updates on performance improvement projects during weekly town halls. According to the patient safety manager, staff monitor patient safety events through the Joint Patient Safety Reporting system (a database VA staff use to report patient safety events) to identify trends.³⁴

However, the OIG team found that facility leaders frequently used email instead of in-person or virtual committee meetings. In these instances, leaders sent information (labeled as minutes) to committee members via email for review and votes. The chief of quality and patient safety told the OIG that leaders used this process when members could not attend a scheduled meeting. The team further reviewed facility policies and medical staff bylaws and found one associated reference, limited to instructions on how staff document attendance for email meetings.

While several committees used email meetings, the Healthcare Delivery Board, which is responsible for continual review of clinical care quality and medical staff credentialing, conducted 10 of its 12 meetings by email in FY 2025. The Joint Commission standards MS [Medical Staff] 16.01.01 and LD [Leadership] 11.01.01 include expectations for medical staff representation at governing body meetings, as well as physician leadership and oversight for issues related to patient safety and patient satisfaction.³⁵ The facility's medical staff bylaws require the Healthcare Delivery Board to review clinical care quality.³⁶ The bylaws also require each clinical service to hold meetings with documented discussions, conclusions, recommendations, actions, and follow-up.

The Chief of Staff did not provide a reason for the frequent use of email meetings beyond scheduling conflicts. The OIG is concerned that reliance on email meetings reduces active member interactions and robust discussions, which are vital for decision-making, accountability, and optimal clinical outcomes.

³³ VA OIG, [Comprehensive Healthcare Inspection of the West Texas VA Health Care System in Big Spring](#), Report No. 22-00037-117, May 11, 2023; The Joint Commission, *Final Accreditation Report, West Texas VA Health Care System*, February 9, 2024.

³⁴ VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook, Version 6.0*, last updated October 1, 2025.

³⁵ The Joint Commission, *Standards Manual*, E-edition, MS 16.01.01 and LD 11.01.01, March 1, 2026.

³⁶ VA West Texas Health Care System, *Bylaws and Rules of the Medical Staff of West Texas VA Health Care System*, revised April 2025.

Recommendation 5

The Director evaluates the Healthcare Delivery Board and takes actions when warranted to provide proper oversight of clinical care quality in accordance with Joint Commission standards Medical Staff 16.01.01 and Leadership 11.01.01.

X Concur

 Nonconcur

Target date for completion: Completed

Director Comments

The VA West Texas Healthcare System has completed an evaluation of the Healthcare Delivery Board and implemented corrective actions to ensure proper oversight of clinical care quality in accordance with Joint Commission standards MS 16.01.01 and LD 11.01.01. The facility provided 6 months of Healthcare Delivery Board meeting minutes as evidence that the Healthcare Delivery Board has consistently held real time virtual board meetings for the past 6 months.

OIG Comments

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



INTEGRATED VETERAN CARE

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.³⁷ 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

The facility delivers primary care services through 18 teams across the facility's locations. At the time of the OIG February 2026 site visit, primary care leaders identified vacancies for providers, a nurse manager, registered nurses, a licensed practical nurse, and medical support assistants.

³⁷ "Community Care," VA, accessed June 29, 2026, <https://department.va.gov/vha/community-care>.

The OIG team found the facility's primary care panel sizes (number of patients assigned to a care team) averaged 104 percent of VHA's expected capacity, and 9 of the 18 teams exceeded the capacity. According to VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, primary care panel capacity is based on variables such as staffing, number of rooms, and provider types.³⁸

Additionally, the OIG team found average new patient wait times were about 18 days for the third quarter of FY 2025. During interviews, the associate chief of staff of ambulatory care said the wait time at the time of the site visit in February 2026 was about 25 days. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is more than 20 days.³⁹ The OIG understands that provider vacancies, along with large panel sizes, can extend wait times for new patients. Based on facility documents received in June 2026, primary care leaders added a team at the Abilene clinic and plan to add a team at the Odessa clinic in the future to increase access to care.

The associate chief of nursing for outpatient services reported that a primary care clinic reduced new patient wait times by implementing nurse-only intake appointments prior to provider visits. The intake appointments focus on vital signs, height, weight, medications, paperwork, and how the clinic operates. This approach allowed providers to have the entirety of the new patient appointment time, and other clinics have subsequently adopted the process. The OIG did not make a recommendation because leaders are taking actions to improve access.

Community Care Staffing and Access to Care

During the OIG's February 2026 inspection, the chief nurse of community care services reported the following vacancies: one nurse manager, two registered nurses, and one business manager. The OIG team found that from January through November 2025, the average time it took staff to schedule a community care appointment was 10 days, while VHA's *Consult Timeliness Standard Operating Procedure* requirement is for 7 days.⁴⁰ The chief nurse stated the facility offers some specialty care services, but due to its large geographic area (approximately 37,000 square miles), patients often receive community care referrals due to drive times. However, the facility wait times were approximately 50 percent below VHA's national average of 20 days for the same time period, so the OIG did not make a recommendation.

³⁸ VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

³⁹ 38 C.F.R. § 17.4040 (2025).

⁴⁰ 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.⁴¹

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).⁴² HCHV2 measures the percentage of veterans who are discharged from 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).”⁴³

Performance and Improvement Highlights

- The facility’s program met the exit to permanent housing (HCHV1) target for FY 2025 and sustained the performance through the second quarter of FY 2026.⁴⁴
- The program missed the negative exit (HCHV2) target for FY 2025 through quarter two of FY 2026. The acting chief of the social work service stated the program’s

⁴¹ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴² 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.

⁴³ VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

⁴⁴ FY 2026 dates are October 1, 2025, through March 31, 2026.

new staff, and lack of a dedicated supervisor from October 2024 through October 2025 for oversight, may have contributed to not meeting the measure.

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.”⁴⁵ The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.⁴⁶

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).⁴⁷

Performance and Improvement Highlights

- The facility’s program did not meet the voucher use (HMLS3) target in FY 2025 through the second quarter of FY 2026. The acting chief of the social work service identified several performance barriers, such as staffing constraints. Although leaders hired new staff, the acting chief said they required time to learn the job and the experienced staff could not take on additional assignments due to their heavy caseloads. The acting chief also said the VHA hiring freeze on new positions prevented leaders from recruiting staff for the San Angelo location; as a result, an employee from another site commuted several hours to provide support.
- The program met the employment (VASH3) target in FY 2025 and sustained performance through the second quarter of FY 2026. The acting chief of the social work service attributed this success to the community employment coordinator and the relationships the coordinator had established with community partners over the years.

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

⁴⁵ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁶ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁷ 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*.

the community after incarceration.⁴⁸ 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).⁴⁹

Performance and Improvement Highlights

- In FY 2025, facility program staff did not enter enrollment data in the VHA database for 11 months due to a staffing vacancy. The acting chief of the social work service explained that a staff member was reassigned due to a licensing issue that prevented them from working independently, and the facility did not have licensed staff available to provide the required oversight. The facility's program also did not meet performance targets through the second quarter of FY 2026.
- The acting chief said leaders attempted to hire a new employee for the veterans justice program specialist position, but the selected applicant declined the offer. This extended the position vacancy period and further limited the program's ability to maintain consistent veteran services.
- Executive leaders acknowledged the licensure issue and stated they had met with national and VISN staff to seek guidance and request assistance. In July 2025, they temporarily assigned another homeless program staff member to maintain basic operations.
- The OIG team interviewed the VISN homeless program coordinator to determine how VISN staff assisted the facility program in FY 2025. The coordinator acknowledged the issues and reported meeting regularly with the facility's program staff to discuss challenges with meeting their performance targets and to educate them about the program, review data sources, and provide updates.
- To attract qualified applicants, executive leaders changed the vacant position for a veterans justice program specialist to a licensed clinical social worker, but the position remained vacant at the time of the February 2026 inspection. Because executive leaders were recruiting for the position and had assigned another staff member to cover basic operations, the OIG did not make a recommendation.

⁴⁸ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

⁴⁹ 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*.

Conclusion

To assist leaders in evaluating the quality of care at the VA West Texas Healthcare System, the OIG conducted an inspection across five domains. The OIG made five recommendations related to water safety; the facility's policy, service-level workflows, and unfavorable trends in test result communications; and committee oversight. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 5. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports. The OIG administered voluntary questionnaires to 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 the facility from February 17 through 23, 2026, and facility leaders provided an update in June 2026 on various areas of the medical facility. 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.⁵⁰ 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*.⁵¹

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.⁵² 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.

⁵⁰ Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

⁵¹ 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.

⁵² 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 1978.⁵³ 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.

⁵³ 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 21, 2026

From: Interim Director, Health Service Area 4.3

Subj: Healthcare Facility Inspection of the VA West Texas Healthcare System in Big Spring

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

To: Director, Office of Healthcare Inspections (54HF03)
Chief Integrity and Compliance Officer (10OIC)

We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA West Texas Health Care System in Big Spring.

HSA 4.3 has reviewed and concurred with the recommendations made by OIG and has reviewed the response and associated plans submitted by VA West Texas Health Care System.

(Original signed by:)

Jamie D. Park, Ed.D.

Interim Health Service Area 4.3 Director, VHA

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 21, 2026

From: Director, VA West Texas Healthcare System (519)

Subj: Healthcare Facility Inspection of the VA West Texas Healthcare System in Big Spring

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

1. We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA West Texas Health Care System in Big Spring.
2. VA West Texas Health Care System has reviewed the recommendations made by OIG and has submitted our response and associated action plans as required.

(Original signed by:)

Robert Hoff
Medical Center Director
West Texas VA Health Care System

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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.