US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Central Texas Healthcare System in Temple

Healthcare Facility Inspection	26-00061-13	November 13, 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 Central Texas Healthcare System (the facility) from April 21 through 23, 2026. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to about 120,600 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 that the proper staff were not notified of temperature and humidity changes in affected areas, as required by VHA Directive 1761, *Supply Chain Management Operations*.[3] The OIG made one recommendation.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG found the facility's policy for test result communications had not been updated to align with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*. The facility also lacked service-level workflows and did not have a process to ensure staff implemented corrective actions for identified issues related to test result communication data, as required by the directive.[4] The OIG made two recommendations.

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have "high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, Facility Trip Pack (VISN [Veterans Integrated Service Network] 17) Olin E. Teague Veterans' Center, last updated February 26, 2026.

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

[3] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

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

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

What the OIG Recommended

1. The Director takes appropriate actions so the proper staff members are notified of supply room temperature and humidity changes, as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.
2. The Director updates the facility's policy for test result communications and develops service-level workflows to comply 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 work with service-level leaders to take corrective action when staff do not communicate test results that require action to patients within seven days, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

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

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 2 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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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.[6] 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.[7]



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.[8]



Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[9]



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.[10]

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

[7] 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.

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

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

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

The VA Central Texas Healthcare System (the facility) serves veterans in 39 counties and includes two medical centers (the Olin E. Teague Veterans' Center in Temple and the Doris Miller VA Medical Center in Waco), a stand-alone multispecialty clinic in Austin, and eight community-based outpatient clinics. The Waco site is home to one of only 12 blind rehabilitation units nationwide, as well as the 30-bed residential Women's Recovery in a Supportive Environment Program, one of four in the country. The women's recovery programs provide comprehensive treatment for women experiencing military sexual trauma, combat-related post-traumatic stress, and substance use disorders. In fiscal year (FY) 2025, the medical care budget was approximately $1.6 billion. The facility had 500 operating beds and served about 120,600 veterans.



Figure 1. *Olin E. Teague Veterans' Center. Source: "VA Central Texas Health Care," VA, accessed May 7, 2026, https://www.va.gov/central-texas-health-care.*

The OIG inspected the facility from April 21 through 23, 2026. The executive leaders referred to throughout this report include the Executive Director (Director), Deputy Executive Director, acting Chief of Staff, Deputy Chief of Staff, Associate Director (Temple), Associate Director (Waco), Associate Director for Patient Care Services, and Assistant Director (Austin).

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

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

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

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

System Shocks

Executive leaders described a January 2026 ice storm that disrupted daily operations at all facility locations for several days. The Director reported that the roads were extremely icy and covered with snow, making travel unsafe across the area.

In response, the Associate Director for Patient Care Services reported that executive leaders activated emergency management processes several days in advance of the storm and converted unused areas, including the Temple site's new unit on the fourth floor, into temporary housing for employees. Leaders used email and social media to maintain communication with veterans and employees. The Director also described efforts to check on vulnerable veterans, such as those who are dependent on home oxygen or experiencing homelessness. Employees ensured adequate oxygen supplies were on hand and provided veterans experiencing homelessness with information about warming shelters.

The Associate Director (Waco) reported an after-action review (a structured analysis after an incident to identify strengths and opportunities for improvement) was completed following the storm. Areas identified for improvement included providing consistent messaging from the incident command and reevaluating the plan for deicing roads and walkways at the Temple and Waco sites.

Employee Experiences

According to the Deputy Chief of Staff, the executive leadership team meets each morning to review patient and employee safety issues, develop action plans, and resolve prior items. Responses to the OIG questionnaire showed that over 70 percent of employees feel comfortable reporting safety concerns, as shown in figure 2. Over half of the respondents cited caring for veterans and pay and benefits as top reasons they stay at the facility. However, over 44 percent identified stress and burnout as top reasons they would leave.

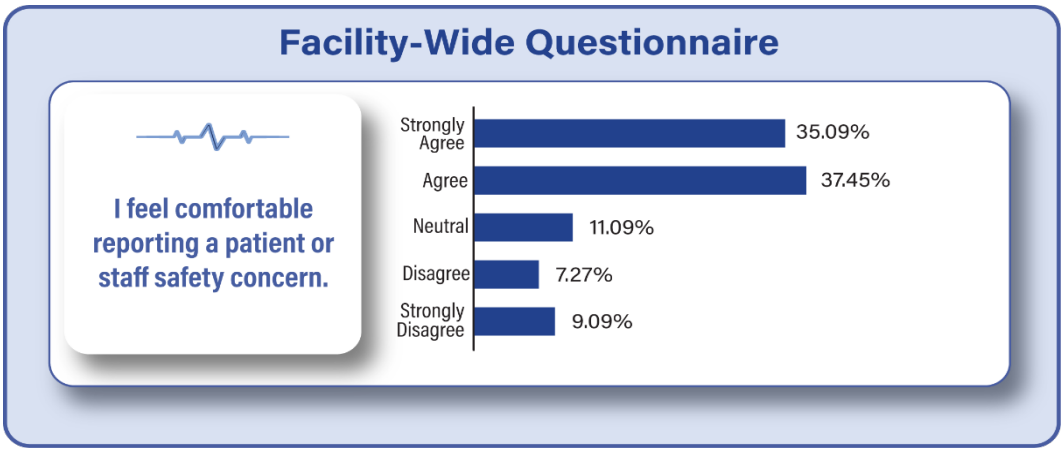


Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

The Associate Director (Temple) stated that recruiting and hiring staff should provide some burnout relief. The Deputy Executive Director reported using recruitment, retention, and relocation incentives for hard-to-recruit positions.

Leaders also discussed several ways they communicate with employees, such as through a monthly director's video, town halls, recognition events, and luncheons at community-based outpatient clinics, as well as a SharePoint site for employees' questions. The Assistant Director (Austin) reported plans to launch a new survey to obtain employee feedback on issues such as burnout.

Veteran Experiences

Executive leaders acknowledged that the facility's FY 2026 quarter two VSignals outpatient score for trust in the facility (92 percent) was below VHA's average of 95 percent, which they attributed to challenges in scheduling veterans' appointments when requested. To address these concerns, leaders made Saturday primary care appointments available for new patients and continued efforts to recruit and hire additional providers. This will be further expanded on in the Integrated Veteran Care section.



Attention to environmental design improves veterans' and staff's safety and experience.[14] 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.[15]

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

[15] 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: A Supplement to the Architectural Barriers Act Accessibility Standards (ABAAS)*, 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.

General Inspection

The OIG team easily navigated to both medical centers, which had clear directional signs, accessible and general parking in surrounding lots, on-site shuttle services, and nearby public bus stops. The Temple site also had a parking garage with bright lighting, security cameras, and emergency phones on each level.

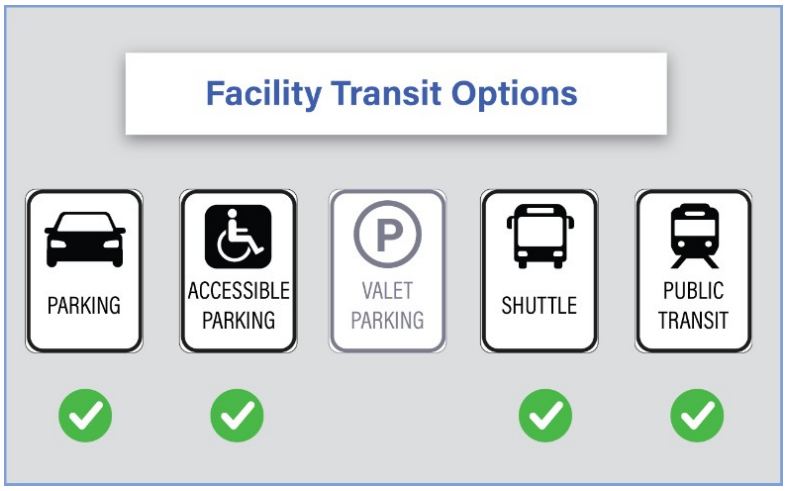


Figure 3. *Transit options for arriving at the facility.*
Source: OIG photos and observations, facility liaison questionnaire, facility parking maps.

Both main entrances were welcoming and had natural light, ample seating, and power-assisted sliding doors. The Temple site also had a covered area for patient drop-off and pick-up and an information desk with limited volunteer staffing.

The OIG team spoke with a Temple information desk volunteer who said they communicate with hearing-impaired veterans using written instructions or louder speech, help visually impaired veterans by escorting them to appointments, and use a telephone translation service when needed. Both locations had color-coded maps and directories on each floor that supported veterans' navigation to clinical and nonclinical areas. Inspectors also noted accessible features such as large-print signs, braille room labels, and elevators with braille and audio cues.



Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG photos and observations and a facility liaison questionnaire response.

The OIG team inspected the medical-surgical unit, intensive care unit, emergency department, primary care clinic, and community living center in Temple, and the primary care clinic and community living center in Waco. Inspected areas at both locations were generally clean with no significant safety, security, or privacy issues identified.

However, in Temple, the OIG team found that the automatic temperature and humidity tracking system did not notify the proper staff

about temperature and humidity changes in the emergency department and primary care clinic supply rooms because of outdated phone contact information. The assistant chief of sterile processing services reported that a review of the inventory system confirmed that none of the affected supplies were used. However, a logistics management specialist acknowledged that although the supply management team had assessed the supplies stored in the supply rooms and removed the affected items, the phone contact information needed to be updated to ensure staff using the supplies were informed. VHA Directive 1761, *Supply Chain Management Operations* requires supply chain notifications when supplies have been compromised by temperature and humidity fluctuations so services can determine if items are safe for patient use.[16] Facility management leaders told the OIG team that the supply chain management department needed to update its rosters to ensure proper staff were notified.

Recommendation 1

The Director takes appropriate actions so the proper staff members are notified of supply room temperature and humidity changes, as required by Veterans Health Administration Directive 1761, *Supply Chain Management Operations*.

__X__ Concur

_____ Nonconcur

Target date for completion: February 28, 2027

Director Comments

The phone contact roster information will be updated immediately

a. The roster will have a date indicating date of most recent update

b. The contact roster will be verified monthly by making 3 randomly selected phone calls to ensure accuracy

    i. Results of the accuracy of the roster will be reported in the Accreditation Readiness Committee

        1. Measure of success is 100% accuracy for 4 consecutive months

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

[16] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.



The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The OIG team found the facility's policy for communicating test results did not meet requirements in VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*. VHA issued the directive on July 11, 2023, requiring facilities to develop a local policy and service-level workflows (which describe the role of various team members in the test result communication process) within 6 to 12 months.[17] The facility's policy, last updated in August 2021, lacked required elements, including how the facility monitors compliance with communication of test result requirements and how providers communicate life-changing results—such as a test suggestive of a cancer diagnosis—to patients at a high risk for suicide. The facility also did not develop required service-level workflows for each service that orders and reports test results.

Without defined workflows, staff may be unclear about their responsibilities, which could lead to inconsistent practices and delays in patient care. During interviews, quality management and executive leaders were unable to provide a reason for not meeting the requirement, although the acting Chief of Staff acknowledged the deficiency and stated their intention to address it.

Recommendation 2

The Director updates the facility's policy for test result communications and develops service-level workflows to comply with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__ Concur

_____ Nonconcur

Target date for completion: Completed

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

Director Comments

Quality Management and Chief of Staff in collaboration with clinical service leaders and executive leadership, will draft a comprehensive local policy for test result communication. The policy will explicitly outline procedures for monitoring compliance and for communicating life-changing results—such as those suggestive of cancer diagnoses—to patients at high risk for suicide. Service-Level Workflow Creation: Service-level workflows will be developed for each clinical service that orders and reports test results. These workflows will define the roles and responsibilities of all team members involved in the communication process, ensuring clarity and consistency. Stakeholder Engagement and Review: Drafts of the policy and workflows will be reviewed by relevant stakeholders, including providers, service leaders, and executive leadership, to ensure practicality and alignment with national standards. Approval and Publication: The finalized policy and workflows will be approved by facility leadership and published by September 25, 2026. Medical Center Policy was published to the Policy Resource Center Intranet for all staff to review. Facility request closure of this item as policy and workflows are all on Policy SharePoint intranet.

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.

VHA Directive 1088(1) requires providers to communicate abnormal test results to patients within seven days of the result being available. Quality management staff said they track abnormal test result notifications through the External Peer Review Program and report results to facility leaders monthly.[18] The OIG team reviewed the facility's FY 2025 performance data and found that staff notified patients with abnormal test results within seven days of the results being available about 49 percent of the time. When staff do not communicate results promptly, patients may experience a delay in follow-up care.

The acting Chief of Staff explained that some providers lacked knowledge about reporting and documentation requirements. In response, quality management staff increased the frequency of facility-wide training in late FY 2025, which included presentations at monthly staff meetings and informational emails to service leaders and providers. Performance improved in FY 2026; however, data for the second quarter show staff communicated abnormal test results within seven

[18] The external peer review program "provides an independent review of medical records to assess the quality of both inpatient and outpatient care provided" by VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, accessed April 21, 2026, https://vaww.qps.med.va.gov/divisions/api/pm/cpm. (This site is not publicly accessible).

days only 66 percent of the time. Service leaders also cited competing demands, particularly for primary care providers, as a barrier to communicating test results within the required time frame.

VHA Directive 1088(1) also requires the Chief of Staff and Associate Director for Patient Care Services to review test result communication data and ensure staff implement corrective actions for identified issues. The acting Chief of Staff and Associate Director for Patient Care Services said they review the data but do not have a process to ensure staff develop improvement actions. The acting Chief of Staff reported relying on service-level leaders to take action when needed but was not aware of instances when this occurred. When leaders do not make sure corrective actions are taken, staff may miss opportunities to improve processes to communicate test results.

Recommendation 3

The Chief of Staff and Associate Director for Patient Care Services work with service-level leaders to take corrective action when staff do not communicate test results that require action to patients within seven days, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__Concur

_____Nonconcur

Target date for completion: April 30, 2027

Director Comments

Quality Management, in partnership with clinical service leaders, has strengthened compliance with Veterans Health Administration Directive 1088(1) by implementing a robust, multi-level process to ensure timely communication of actionable test results. Key actions include:

- Weekly Audits: Conducted to monitor performance and identify gaps in communication.
- Standardized Notification Workflows: Established to streamline the process and ensure consistency across services.
- Clear Escalation Pathways: Formal inclusion of the Chief of Staff and Associate Director for Patient Care Services ensures accountability when communication is delayed or incomplete.
- Targeted Education and Documentation Guidance: Staff receive ongoing training and tools, such as CPRS lab letters, to facilitate timely notifications.
- Performance Monitoring and Corrective Actions: Trends are tracked and shared with services; corrective actions are taken promptly when gaps are identified.

- Oversight and Reporting: Compliance data are reported monthly to the Accreditation Readiness Committee and Clinical Executive Committee. Services receive their specific Communication of Test Results data with expectations for timely corrective action.
- Sustained Compliance: The goal is to achieve four consecutive months of 95% or better compliance, with recent summaries showing improving performance and consistency.

Collectively, these measures establish a robust oversight framework that supports timely Veteran communication, improves reliability, and aligns the organization with national expectations for Communication of Test Results compliance.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Action Plans and Process Improvements

At the time of the inspection in April 2026, the accreditation readiness specialist reported the facility had no recommendations from oversight agencies open (unimplemented) longer than a year. Quality management staff said they track open recommendations and coordinate action plans with service leaders, who provide updates during meetings with the Director. Once the action is closed, quality management staff assign the issue to the appropriate committee to monitor sustainment.

Quality management leaders explained that facility staff report patient safety concerns through the Joint Patient Safety Reporting system (a database for employees to document patient safety events).[19] To identify opportunities for improvement, quality management staff evaluate patient safety events for trends, discuss concerns with executive leaders, and collaborate with oversight committees.

For example, in FY 2025, they identified recurring issues with the emergency response paging systems at the Temple and Austin sites. Defective paging equipment and inaccurate overhead announcements delayed activating emergency response teams. The accreditation readiness specialist said no adverse events occurred, but staff recognized the risk to patient safety. In response, representatives from quality management, police, engineering, and nursing services formed a workgroup to evaluate system vulnerabilities and update related processes. At the time

[19] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, *Version 9.0*, March 2026.

of the inspection in April 2026, staff had implemented changes, such as regularly testing all code buttons and standardizing the dispatcher process for making emergency announcements. While they continue to evaluate performance data, the accreditation readiness specialist provided a process summary document that showed the accuracy and reliability of the emergency paging system had improved.



VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[20] 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 offers primary care at the two medical centers and nine additional outpatient clinics throughout the region, with more than 100 primary care teams. In March 2026, a primary care leader shared facility documents that showed staff vacancies included 19 providers, 13 registered nurses, 1 licensed vocational nurse, and 8 medical support assistants.

Primary care leaders reported that most of the provider vacancies were due to retirements in the past year, and they were hiring new providers. To manage increased workload as a result of the vacancies, leaders used providers from the Veterans Integrated Service Network-owned Clinical Resource Hub (which provides services in areas experiencing gaps in access to care), reallocated medical support assistants and providers across clinics, and redistributed patient teams—sometimes requiring providers to oversee multiple teams.[21]

[20] "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.

[21] VA administers healthcare services through a nationwide network of regional systems referred to as Veteran 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.

A primary care pharmacist reported managing chronic disease prescriptions to assist when there are provider vacancies. The pharmacist added that some pharmacists are often assigned up to five teams, more than the three teams recommended in VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*.[22] Staff felt that increased vacancies and panel sizes (patients assigned to a care team)—with several exceeding the 1,200-patient baseline in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*—led to overwhelming workloads.[23] Primary care leaders shared an improvement initiative that also allowed nurses to manage patients with chronic diseases, such as blood pressure and diabetes, which reduced the need for provider appointments. Leaders reported difficulty recruiting in rural areas; however, most nurse positions were in various stages of hiring.

The Code of Federal Regulations, title 38, section 17.4040 states that veterans may be referred to community providers if the wait time for a primary care appointment is longer than 20 days.[24] The OIG team found that average new patient wait times at the facility were approximately 30 days in FY 2025 and 34 days in the first three quarters of FY 2026. In comparison, average wait times for primary care in the community were approximately 47 days in FY 2025 and 41 days in the first three quarters of FY 2026. Facility staff told the OIG that when they offer patients the option of being seen by a community provider, they also explain the differences in wait times, and the patient can choose the option that best meets their needs.

Primary care leaders said vacant provider positions affected wait times. To improve access, they said primary care clinics now offer provider, pharmacy, and nursing appointments on Saturdays at the Austin and Cedar Park locations.

Community Care Staffing and Access to Care

A community care leader shared facility community care documents from March 2026 that showed vacancies for one provider, two registered nurses, five licensed vocational nurses, and seven medical support assistants. Community care leaders stated that staff for many positions had been hired and were awaiting start dates, and recruitment is ongoing for others.

Other facility documents provided by a community care leader showed the top three community care services in FY 2025 were dental, urology (concerned with the kidneys and bladder) and gastroenterology (concerned with the digestive system).VHA's *Consult Timeliness Standard Operating Procedure* requires staff to schedule appointments for veterans within 7 days of

[22] VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

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

[24] 38 C.F.R. § 17.4040 (2025).

receiving a referral for community care.[25] In April 2026, community care staff took an average of 25 days to schedule patients' first appointments in the community, an improvement from the FY 2025 average of 48 days. Community care leaders said the scheduling requirement is difficult to meet because local community care specialty providers also have numerous requests from other, non-VA facilities to review, a process that takes time and occurs before an appointment is scheduled. However, for mental health, leaders noted that community care staff can use an online tool to schedule appointments with providers in the community. The OIG team found that March 2026 data showed mental health scheduling did not take as long and staff averaged 5 days to schedule patients' first community mental health appointments.

Community care leaders shared a list of process improvement projects, which included a national VA project to streamline requests for services (to receive approval when patients need additional care) from community providers. The facility's high referral volumes led to a backlog, which exceeded 3,000 by May 2025. In response, staff reorganized electronic fax folders, created a dedicated request line, and trained community providers to submit their requests to the corresponding facility community care folder. These focused efforts resolved the backlog by January 2026.



The OIG reviewed Health Care for Homeless Veterans (HCHV), Housing and Urban Development-Veterans Affairs Supportive Housing (HUD-VASH), and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The inspection team analyzed enrollment and performance data and interviewed facility program staff.

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[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

[25] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

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

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]

Performance and Improvement Highlights

- The facility program met the discharge to permanent housing (HCHV1) target in the first and second quarters of FY 2026. The HCHV coordinator explained their success is achieved through staff expertise, veteran employment services, effective partnerships with Supportive Services for Veteran Families (which uses private or nonprofit grants to support very low-income veteran families who are in or transitioning to permanent housing), and the HUD-VASH program (discussed below).[29]
- The facility program also met the negative exit (HCHV2) target in the first two quarters of FY 2026. The HCHV coordinator attributed this to using behavioral contracts (written agreement that outlines expected behaviors, rules, and consequences) and providing veterans with second chances after rule violations, whenever appropriate, to reduce negative exits.

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]

[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.*

[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*.

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]

Performance and Improvement Highlights

- The HUD-VASH supervisor said program staff worked with six public housing agencies in Temple, Austin, and Waco, and they had 1,000 vouchers allocated, including 200 project-based vouchers (which are assigned to a building or unit).
- The facility program did not meet the voucher use (HMLS3) target for the first two quarters of FY 2026. Program staff explained that some veterans' incomes had increased to levels that made them no longer eligible for HUD-VASH vouchers, and fewer were participating in the Austin and Waco programs.
- The facility program met the employment (VASH3) target in the first two quarters of FY 2026. Program staff attributed meeting the goal to their established case management processes to connect veterans with employment opportunities.

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]

Performance and Improvement Highlights

The facility did not meet the enrollment (VJP1) target for the first two quarters of FY 2026, missing the target by approximately 5 percent each quarter. The homeless program coordinator and staff identified the lack of a healthcare for re-entry veterans specialist, a position vacant since March 2024 and later eliminated, as a key barrier. The coordinator said the role is essential for prison outreach, group engagement, and assessments—activities that played a major role in

[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.*

[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.*

enrolling veterans. Staffing constraints and core veteran treatment court duties prevent social workers from conducting direct jail outreach. Consequently, they depend on established community partners who notify the team when incarcerated veterans require connection to VA services. Staff also described positive situations, as follows:

- Staff reported strong relationships with judges, attorneys, and local agencies. They noted that Travis County, which includes Austin, is particularly receptive to mental health and substance use treatment and offers video appointments in some jails to improve access to veterans.
- Additionally, the VA Veterans Justice Outreach team participates in the state's Department of Public Safety Behavioral Threat Assessment Management, which brings together crisis intervention teams from multiple counties that identify and support individuals exhibiting problematic behavior, and contact veterans before police involvement.
- Staff also noted improved law enforcement training, including required courses on posttraumatic stress disorder and traumatic brain injury, which helps officers assist veterans they encounter.

Conclusion

To assist leaders in evaluating the quality of care at the VA Central Texas Healthcare System, the OIG conducted an inspection across five domains. The OIG made three recommendations related to temperature and humidity notifications and test result communications. Facility leaders implemented some corrective actions, which resulted in the OIG closing recommendation 2. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[35] 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 physically inspected various areas of the medical facility from April 21 through 23, 2026, and interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. 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.[36] 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.*[37]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[38] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

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[35] 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.

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

[37] 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.

[38] 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.[39] 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.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 23, 2026

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

Executive Director, Health Service Area 4.3

Subj: Healthcare Facility Inspection of the VA Central Texas Healthcare System in Temple

To: Director, Office of Healthcare Inspections (54HF05)

Chief Integrity and Compliance Officer (10OIC)

1. We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA Central Texas Health Care System in Temple.
2. HSA 4.3 and VISN 4 has reviewed and concurred with the recommendations made by OIG and associated action plans submitted by VA Central Texas Health Care System.

(Original signed by:)

Fernando O. Rivera, FACHE
Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 19, 2026

From: Director, VA Central Texas Healthcare System (674)

Subj: Healthcare Facility Inspection of the VA Central Texas Healthcare System in Temple

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

Executive Director, Health Service Area 4.3

1. We appreciate the opportunity to review and comment on VA OIG report, Healthcare Facility Inspection of the VA Central Texas Health Care System in Temple.
2. VA Central 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:)

Christopher Myhaver
Medical Center Director
Central 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.