US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Amarillo Healthcare System in Texas

Healthcare Facility Inspection	26-00042-279	September 28, 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 Amarillo Healthcare System (the facility) from February 9 through 12, 2026. The facility is rated as *medium complexity* and in fiscal year 2025, provided care to about 25,000 unique 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 team found damage to walls and floors, stained ceiling tiles, dirty equipment and items on the floor of clean utility rooms, which did not comply with VHA Directive 1608(1), *Comprehensive Environment of Care Program*. Also, staff did not monitor temperature and humidity in some medication rooms, in accordance with VHA Directive 1108.07(2), *General Pharmacy Service Requirements*.[3] The OIG made two recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG made no recommendations.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.

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[1] VHA classifies facilities based on their complexity level. Medium-complexity facilities have "medium volume, low risk patients, few 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." VA, Facility Trip Pack (VISN [Veterans Integrated Service Network] 17) Thomas E. Creek Department of Veterans Affairs Medical Center, last updated January 7, 2026.

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

[3] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023; VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

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

- **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 develops and implements a plan to repair and maintain facility walls, floors, and ceilings, and keep clean and dirty items separate, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
2. The Director implements measures to monitor medication room temperature and humidity in the intensive care unit and community living center, in accordance with Veterans Health Administration Directive 1108.07(2), *General Pharmacy Service Requirements*.

VA Comments and OIG Response

The Health Service Area Director and facility Director concurred with the findings and 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 recommendation, the OIG will follow up on the planned actions until they are completed.

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Abbreviations

CLC	community living center
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[5] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

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

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

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

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

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[9]

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

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

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

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

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

The VA Amarillo Healthcare System (the facility) consists of the Thomas E. Creek VA Medical Center in Amarillo and four community-based outpatient clinics in Lubbock, Dalhart, and Childress, Texas, and Clovis, New Mexico. In fiscal year (FY) 2025, the facility had a medical care budget of approximately $597 million and provided care to about 25,000 patients. It had 39 hospital, 7 domiciliary, and 120 community living center (CLC) beds.[10]

Figure 1. *Facility photo.*
Source: "VA Amarillo Health Care," VA, accessed April 7, 2026, https://www.va.gov/amarillo-health-care.

The OIG inspected the facility from February 9 through 12, 2026. The executive leaders referred to throughout this report include the Medical Center Director (Director), Associate Director, Chief of Staff, Acting Associate Director for Patient Care Services, Assistant Director, and Chief Quality Officer.

CULTURE

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

[10] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/CLC.

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

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

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

System Shocks

Executive leaders reported that in late November 2025, the medical center faced a significant system shock when a heating system stopped functioning. The outage lasted for approximately three months because the replacement parts for the aged air-handling unit were not readily available to order. In response, engineering staff restored partial heat by reactivating old steam furnaces. However, some areas, including a medical surgical unit, remained without adequate heat. Staff relocated some veterans to warmer areas of the medical center and deployed space heaters throughout the affected locations. The Associate Director said the facility's infrastructure plan includes replacing other older systems to prevent similar disruptions in the future.

Employee Experiences

Employee respondents to the OIG questionnaire described communication from executive leaders as clear and frequent. Executive leaders reported they emphasize transparency and use multiple channels to communicate, including a weekly newsletter (called *VA Reporter*), a *Report a Concern* feature on the facility webpage, and regular rounding (walking through work areas and speaking to employees). Respondents said they remain committed to their jobs because of the VA mission, job satisfaction, and strong teamwork. While more respondents indicated comfort than discomfort with suggesting ways to improve their work environment, as shown in figure 2, responses on whether the culture was moving in the right direction were more mixed.

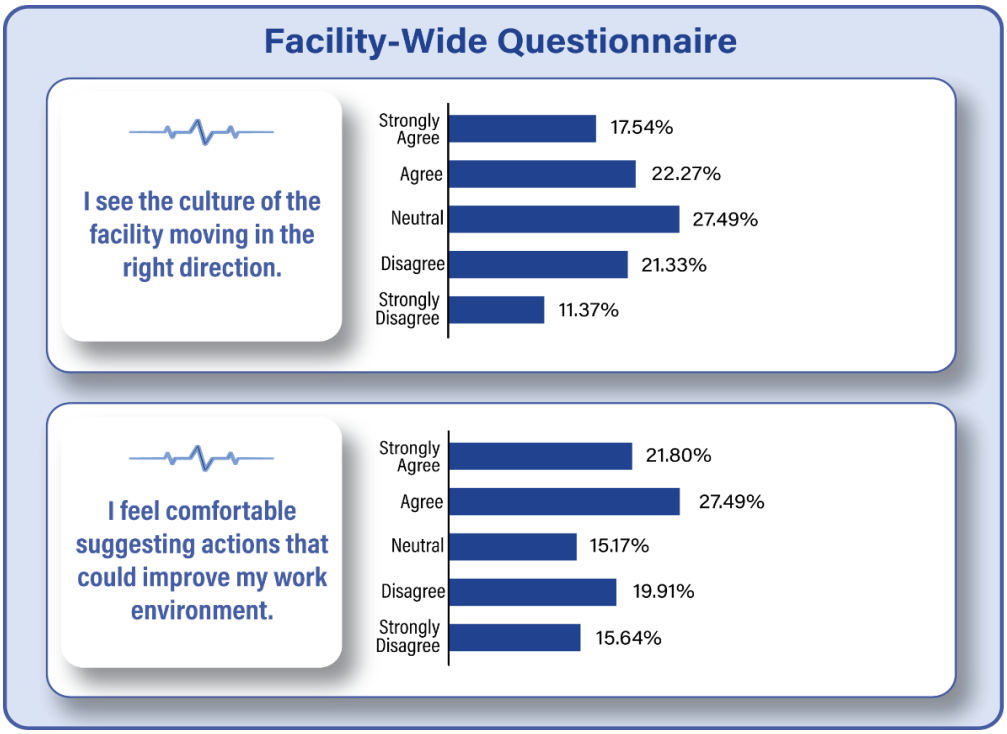

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Executive leaders reported using the following strategies to gather feedback and stay connected to employees:

- The leaders implemented the *Walk in Your World* program, in which they and the service chiefs shadow frontline employees quarterly, wear the same uniforms, and perform their daily tasks. This helps leaders understand employees' challenges, reduce barriers, and build trust between them. It has led to tangible improvements, such as updating dialysis consent policies and streamlining medication management in the CLC.
- The Director regularly visits all sites and permanently stationed the Assistant Director at the Lubbock clinic to reduce varying perspectives between employees at the medical center and outlying clinics. This ensures executive leaders' representation, advocacy, and direct engagement with employees in all facility locations.
- Leaders also implemented a change management initiative in which they assign employees to departments other than their own for 120 days to address operational challenges. At the time of the inspection in February 2026, the Director told OIG inspectors that current efforts focus on improving patient satisfaction and reducing falls.

Veteran Experiences

VSignals responses demonstrate strong confidence and trust in the facility. In 2024, the most recent data available, approximately 94 percent of the facility's survey respondents reported they trust VA outpatient care. This is on par with VA's average trust rating. According to executive leaders, veterans routinely travel from cities such as Dallas, Albuquerque, and Oklahoma City—and some even relocate to Amarillo—to receive care at the facility. The leaders attributed this to employees' reputation for providing a welcoming environment and their dedication to meeting veterans' needs.

However, a patient advocate identified community care billing issues and difficulty reaching primary care providers by telephone as common concerns raised by veterans.[14] The Director explained that billing concerns typically arise when community care providers send invoices to veterans instead of to the facility. The community care chief addressed the issue by providing guidance during a town hall meeting, offering veterans instruction on how to respond if they received an invoice, and working with community care staff to ensure the bills were redirected and processed. Executive leaders attributed the phone issues to call center processes that prevent

[14] 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.

direct calls to providers, but employees mitigate this by promoting the use of My HealtheVet (an online portal where veterans can contact their providers through email).

Other efforts employees use to improve veterans' experiences include the following:

- To keep veterans informed, employees hold monthly virtual town halls and quarterly in-person sessions at the medical center and Lubbock clinic, plus annual sessions at the facility's other community-based outpatient clinics. They also hold virtual town halls specifically to address the needs of women veterans.
- To increase communication options, veterans receive reminders and updates through newsletters, emails, and social media streams of town halls that remain viewable anytime.
- To expand outreach and reinforce trust, executive leaders attend graduations from veterans treatment court (programs where veterans receive treatment monitored by a judicial team) and support Veterans Justice Program activities, as discussed in the Veteran-Centered Safety Net section.[15]

[15] VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[16] 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.[17]

General Inspection

At the medical center, the OIG team noted clear directional signs, adequate parking with accessible spaces for those with disabilities, and nearby public bus stops. The main entrance had a covered area for loading and unloading passengers and power-assisted doors.

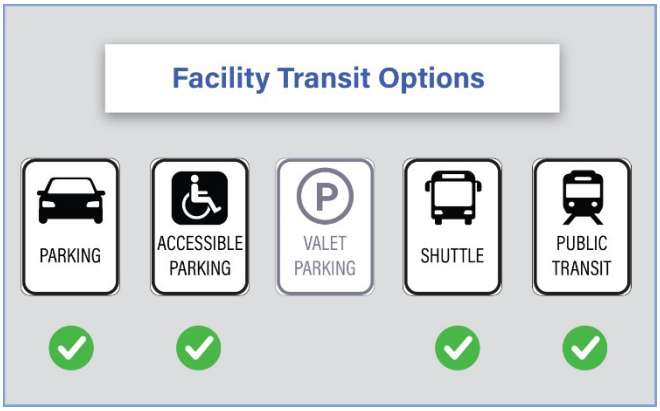

Figure 3. *Transit options for arriving at the facility. Source: OIG inspector photos and observations, facility liaison questionnaire response, and facility parking maps.*

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

[17] 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.

Volunteers at the information desk assisted with directions, answered questions, and helped veterans get to appointments. The volunteers said they communicate with hearing-impaired individuals by speaking louder or writing instructions. Inspectors also observed large print signs throughout the facility and navigated the space easily. Elevator signs and room placards had braille text, and elevators had audio cues to support accessibility.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: Inspector observations, facility liaison questionnaire response, and parking maps.

However, the OIG team also found several safety and cleanliness problems. The team inspected the medical surgical units, intensive care unit, emergency department, primary care clinics, and CLC and observed

- wall damage in the emergency department and CLC hallways,
- damaged floors in the CLC,
- stained ceiling tiles in the emergency department waiting area and CLC dining area, and
- dirty equipment and items on the clean utility room floor in the CLC.

VHA Directive 1608(1), *Comprehensive Environment of Care Program*, requires facilities to maintain a safe and clean healthcare environment.[18] Clean and dirty items stored together can spread germs onto clean supplies, and damaged or dirty care areas trap bacteria, which may infect patients and staff. The Associate Director identified staffing losses and the facility's age as barriers to maintenance but noted leaders prioritize safety concerns and are making improvements.

Recommendation 1

The Director develops and implements a plan to repair and maintain facility walls, floors, and ceilings, and keep clean and dirty items separate, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

[18] VHA Directive 1608(1).

____Nonconcur

Target date for completion: April 1, 2027

Director Comments

The Director reviewed the recommendation and did not identify any additional factors contributing to noncompliance. Prior to the departure of the OIG inspection team, the facility convened a multidisciplinary group to evaluate the environment of care concerns in the Community Living Center (CLC). Work orders were submitted for the identified deficiencies, and those work orders have been completed. A project to address the peeling wallpaper in the CLC is scheduled for completion in early FY27. To ensure continued compliance, services will conduct monthly service-level environment of care rounds. Compliance will be monitored until 90% of services complete these monthly rounds, and compliance is sustained for six consecutive months.

The facility will also establish a standardized process to ensure proper separation of clean and dirty items, accompanied by targeted staff education. Managers will perform weekly inspections of clean utility rooms to ensure no dirty items are present. Compliance will be monitored until 90% compliance is achieved and sustained for six consecutive months.

Compliance will be reported to the Executive Health Care Committee through the governance structure.

Inspectors also found staff did not monitor the temperature and humidity in the intensive care unit and CLC medication rooms. VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, states that medications must be stored at 68–77 degrees Fahrenheit, with relative humidity at 30–60 percent.[19] Additionally, the facility's *Temperature and Humidity Monitoring Policy* requires monitoring in all medical supply storage areas.[20] The Associate Director reported being unaware that staff did not monitor these rooms, but said staff would correct the issue. If staff do not monitor temperature and humidity in areas where medications are stored, they may be unaware of environmental conditions that affect medication integrity.

Recommendation 2

The Director implements measures to monitor medication room temperature and humidity in the intensive care unit and community living center, in accordance with Veterans Health Administration Directive 1108.07(2), *General Pharmacy Service Requirements*.

__X__Concur

[19] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

[20] Amarillo VA Health Care System, MCP 90-13, *Temperature and Humidity Monitoring Policy*, May 1, 2023.

____Nonconcur

Target date for completion: Completed

Director Comments

Healthcare system response: The Director evaluated this recommendation and determined that insufficient staff knowledge contributed to the observed noncompliance. Pharmacy Service monitors temperature and humidity for all medication rooms; however, during interviews, nursing staff were unable to speak to the established process. To address this gap, targeted education has been provided to nursing staff, and signage has been posted identifying the appropriate point of contact for any temperature or humidity concerns. 98% of staff received either in-person instruction or email with read receipts.

Monitoring reports for the cited medication rooms over the past year have been reviewed. While humidity excursions were noted, Pharmacy Service evaluated the potential impact on medications based upon each medication at the time of the excursions. No medications were adversely affected, and none required disposal. Pharmacy Service will continue monitoring temperature and humidity for all medication rooms to ensure ongoing compliance.

The facility requests closure of this item.

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.

Additionally, the team observed water on the floor in the CLC common bathing room that did not drain, which increases fall risks for patients and staff. The nurse manager reported that a patient had been given a bath just before the OIG team entered the room. The manager described and demonstrated the process staff use to remove water after each patient is bathed. The chief of engineering also said they are working with a contractor to repair the floor. Because facility staff have a process to remove the water, the OIG did not make a recommendation.

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

Communication of Urgent but Noncritical Test Results

The facility had a policy for communicating test results to providers and patients and processes for communication within specific departments (service-level workflows), as required by

VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[21] The policy included after-hours notification of critical results and assignment of a surrogate when a provider is unavailable or has left the facility.

Quality management staff said they use data from the External Peer Review Program to monitor communication of test results requiring follow-up to patients; they report these data to executive leaders during quarterly Medical Executive Board committee meetings.[22] The OIG team reviewed FY 2025 performance data and found that providers communicated abnormal test results to patients within seven days, as required by VHA Directive 1088(1), 100 percent of the time. One service chief said that quality management and health informatics staff developed an additional process to track the time between test results becoming available in the electronic health record system and providers notifying patients. The Chief of Staff reported reviewing the internal tracking data weekly and alerting service chiefs when results remain unaddressed for more than three days. Facility leaders said they met with providers to address potential concerns and initiated corrective action plans when needed.

Action Plans and Process Improvements

The facility had no recommendations from oversight reports related to communication of test results at the time of the inspection in February 2026. Quality management staff stated the facility's Continuous Readiness Committee oversees all action plans from the time an oversight body issues a recommendation through closure, and ensures staff sustain improvements. The quality and patient safety chief explained that the staff member assigned to each action plan updates the committee during monthly meetings. Additionally, executive leaders said they reviewed oversight reports from other VA facilities to determine whether similar issues could affect their own facility and created action plans when needed.

Quality management leaders said they identify opportunities for process improvement through reviews of patient safety reports and facility data in areas where they track performance. Quality management staff explained that they engage frontline staff in performance improvement by attending team huddles (brief meetings to discuss patient care) and staff meetings to update them on projects, share performance data, and encourage them to highlight changes they have made to strengthen processes in their work areas. Additionally, quality management staff promote continuous learning through presentations at new employee orientations and patient safety forums. Staff said executive leaders show their support for patient safety and process

[21] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024; Amarillo VA Health Care System, "Communication of Test Results" (standard operating procedure), March 6, 2025.

[22] The External Peer Review Program "provides an independent review of medical records to assess the quality of both inpatient and outpatient care provided" across VHA. "Clinical Performance Measurement Program," VHA Office of Quality and Patient Safety, last updated October 23, 2024, https://vaww.qps.med.va.gov. (This site is not publicly accessible.)

improvements in multiple ways, such as beginning each employee town hall with a patient safety story and frequently engaging with staff and veterans about potential areas for improvement.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[23] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

Primary care leaders stated that clinics are below the 20-day wait time eligibility standard for referral to community care, as stated in the Code of Federal Regulations, section 17.4040.[24] The OIG reviewed facility data and verified that new patients are seen within an average of 11 days, and established patients within 2 days.

Primary care staff also explained that recent retirements of some specialty care providers at the facility shifted additional responsibilities to primary care. They now submit more referrals for community care and manage medications for affected patients. During an OIG interview, primary care staff reported increased frustration with the changes, though they acknowledged the situation was temporary while leaders recruit new specialty and primary care providers. Staff said a primary care leader supports and assists staff by providing patient care to reduce workload.

Community Care Staffing and Access to Care

A community care leader provided a report that showed staff scheduled 48 percent of community care appointments within the seven days required by VHA's *Consult Timeliness Standard Operating Procedure* in quarter one of FY 2026.[25] However, for appointments that exceeded the scheduling requirement, leaders attributed the delays to limited numbers of specialty care providers in the community.

Community care referrals increased 17 percent in the first quarter of FY 2026 compared to the first quarter of FY 2025. Primary care leaders and staff reported that patients can wait over 100 days for some specialty care appointments, so facility staff refer them to virtual providers

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

[24] 38 C.F.R. § 17.4040 (2025).

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

through the Veterans Integrated Service Network (VISN) Clinical Resource Hub (which provides support when local facilities have vacancies).[26] Additionally, the Chief of Staff reported successfully securing faster appointments for urgent cases by calling community providers directly.

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.[27]

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).[28] HCHV2 measures the percentage of veterans who are discharged from the contracted emergency residential services or

[26] VISNs are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise. "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

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

[28] 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.

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)."[29]

Performance and Improvement Highlights

- Facility program staff assist veterans across the northernmost region of Texas and in Clovis, New Mexico. Staff assess veterans and refer those who live in rural areas to community partners, including Texas Panhandle Centers (a state mental health agency) and Panhandle Community Services (a public housing agency).
- The facility program met the discharge to permanent housing (HCHV1) target from FY 2025 to the time of the inspection in February 2026. Staff attributed this achievement to supporting veterans through continuous outreach and case management, from the time they enter the program until they obtain stable housing.
- However, the program missed the negative exit (HCHV2) target from FY 2025 through the time of the inspection in February 2026. Staff said their contracted residential program has only 13 beds, so even a small number of negative discharges adversely affects the performance metric. To reduce negative exits and improve collaboration, program staff and contract providers now hold a planning meeting to discuss program rules and housing options for each veteran.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[30] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[31]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[32]

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

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

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

[32] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Performance and Improvement Highlights

- Facility program staff reported they work with three public housing agencies and handle 221 assigned vouchers in Amarillo and 95 in Lubbock. The program missed the voucher use (HMLS3) target for FY 2025 but was meeting it at the time of the inspection in February 2026. The program manager stated that in October 2025, a social worker and peer support specialist began to assist each new program participant throughout the housing process, which reduced voucher expirations caused by unsigned lease agreements and improved performance on the metric.
- The program did not meet the employment (VASH3) target for FY 2025 or at the time of the inspection. Staff explained they focused on housing stabilization versus employment because employment is a measure but not a requirement for the program.
- Program staff helped unemployed veterans apply for VA and Social Security benefits as well as food assistance programs. They also supported veterans as they prepared for interviews, created résumés, and searched for jobs. Additionally, staff referred veterans to Compensated Work Therapy, a VA program that provides rehabilitation services and promotes job opportunities for veterans with mental health challenges.[33]

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.[34] 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).[35]

Performance and Improvement Highlights

- Facility program staff conducted outreach at jails, prisons, probation offices, veterans' personal homes, and veterans treatment courts in Amarillo. Staff received referrals from veterans, law enforcement, judges, and community partners.

[33] "Compensated Work Therapy," VA, last updated June 15, 2026, https://department.va.gov/vha/cwt.

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

[35] 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.*

- The program did not meet the enrollment (VJP1) target for FY 2025. Staff reported outreach and enrollment declined due to a prolonged vacancy in a social worker position, which resulted in the loss of coverage for prisons in west Texas. With full staffing of three social workers, early FY 2026 data indicated improvement, and staff anticipate continued progress with enrolling veterans.

Conclusion

To assist leaders in evaluating the quality of care at the VA Amarillo Healthcare System, the OIG conducted an inspection across five domains. The OIG made two recommendations related to safety and cleanliness. Facility leaders have started to implement 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 facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[36] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from February 9 through 12, 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[37] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[38]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[39] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[36] The prior OIG and accreditation reports covered the time frame of October 1, 2022, through November 30, 2025—the most recent available at the time of the inspection.

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

[38] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[39] Self-selection bias is when individuals with certain characteristics choose to participate in a group, and response bias occurs when participants "give inaccurate answers for a variety of reasons." Dirk M. Elston, "Participation Bias, Self-Selection Bias, and Response Bias," *Journal of American Academy of Dermatology* (2021): 1-2, https://doi.org/10.1016/j.jaad.2021.06.025.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[40] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: September 11, 2026

From: Interim Executive Director, Health Service Area 4.3

Subj: Healthcare Facility Inspection of the VA Amarillo Healthcare System in Texas

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 Amarillo VA Health Care System.
2. HSA 4.3 has reviewed and concurred with the recommendations made by OIG and has reviewed the response and associated plans submitted by Amarillo VA 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: August 28, 2026

From: Director, VA Amarillo Healthcare System (504)

Subj: Healthcare Facility Inspection of the VA Amarillo Healthcare System in Texas

To: Director, VISN 4 (10N4)

1. Thank you for conducting the OIG Healthcare Facility Inspection review February 9 through 12, 2026, at the Amarillo VA Health Care System.
2. The recommendations have been reviewed. Amarillo concurs with both recommendations.
3. A plan of action for each of the two recommendations is attached. The two plans of action have been carefully analyzed and will be implemented and monitored through satisfactory completion.
4. I have reviewed the document and concur with the response as submitted.

(Original signed by:)

Rodney S. Gonzalez, MD
Director

OIG Contact and Staff Acknowledgments

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.