US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA New Mexico Healthcare System in Albuquerque

Healthcare Facility Inspection	26-00043-232	August 26, 2026

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To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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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 New Mexico Healthcare System (the facility) from February 3 through 5, 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 84,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The OIG found the facility lacked written workflows (which outline staff roles in communicating test results) for all departments, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] Additionally, the test result policy submitted to inspectors by facility leaders did not include a process for assigning a designee (surrogate) provider when the provider who ordered the tests is unavailable or leaves the facility, which the directive also requires. The OIG made one recommendation.

[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high volume, high-risk patients, many complex clinical programs, with medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." VA, "Facility Trip Pack: (VISN 22) Raymond G. Murphy Department of Veterans Affairs Medical Center," updated October 23, 2025.

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

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

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness or have recently been incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. The Director develops workflows for all services that communicate test results to patients and includes the process for assigning designees (surrogates) for providers who order tests in the facility's policy, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients.*

VA Comments and OIG Response

The Health Service Area Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C). Based on information provided, the OIG considers the recommendation closed.

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

Abbreviations

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

Contents

Introduction

The Office of Inspector General's (OIG's) 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 New Mexico Healthcare System (the facility) opened in August 1932. It includes the Raymond G. Murphy VA Medical Center and 13 community-based outpatient clinics in Colorado and New Mexico. The facility has 5 compensated work therapy, 167 hospital, 70 domiciliary, and 36 community living center beds.[10] In fiscal year (FY) 2025, its medical care budget was approximately $967 million.[11]

Figure 1. *Facility photo.*
Source: "Raymond G. Murphy Department of Veterans Affairs Medical Center," VA, last updated February 4, 2025, https://www.va.gov/new-mexico-health-care/locations.

The OIG inspected the facility from February 3 through 5, 2026. The executive leaders referred to throughout this report included the Medical Center Director (who has served since June 2024), Associate Director (since April 2024), Acting Associate Director for Patient Care Services (since October 2025), Chief of Staff (since April 2025), and Acting Assistant Director (appointed in October 2025). As of June 4, 2026, the Associate Director for Patient Care Services and the Assistant Director positions remained filled by acting staff.

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.[12] 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

[10] Compensated work therapy "provides evidence based and evidence informed vocational rehabilitation services" for veterans as well as other supports and partnerships for employment. "Compensated Work Therapy," VA, last updated June 15, 2026, https://department.va.gov/vha/cwt. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. 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/VA CLC.

[11] VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack-Operational Statistics Table FY2026 Through March," VHA Support Service Center, updated April 7, 2026, https://reports.vssc.med.va.gov. (This web page is not publicly accessible.)

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

assess their level of trust in VA).[13] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[14]

System Shocks

Respondents to the OIG questionnaire identified executive orders and memorandums, such as the deferred resignation program and hiring freeze (in effect from January 20, 2025, to October 15, 2025), as system shocks that placed a significant strain on the facility.[15] Executive leaders said there were vacancies across the system because of the actions, and stressed the effects of fewer nurses, anesthesiologists, and interventional cardiologists (who perform invasive cardiac procedures).

At the time of the inspection in February 2026, the number of available beds had decreased by 75 because of staff losses, which also left the facility unable to perform some surgical procedures. For example, the facility could no longer perform surgery to treat ST elevated myocardial infarction (STEMI), a heart attack caused by complete blockage of a coronary artery. Executive leaders said they had placed the emergency department on diversion (closed to ambulance service) for this procedure approximately one and a half years prior to the inspection. They also responded by redistributing duties and prioritizing essential services to maintain patient care, such as having housekeeping employees only clean patient care areas. Executive leaders stated they reviewed each service to determine which could operate safely with existing staffing levels. Additionally, they developed agreements to send patients to other local hospitals when certain procedures were not available at the facility; the patients then returned to the facility for postoperative care.

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

[14] 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.

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

Employee Experiences

Most respondents to the OIG questionnaire reported they stayed at the facility because they believe in VA's purpose and the importance of serving veterans. When asked what might make them leave, 43 percent noted stress and burnout, while 27 percent indicated they have no plans to leave. Only 26 percent of respondents felt the facility's culture was moving in the right direction. This points to disruptions in employee engagement, which leaders attributed to high turnover among executive leaders.

Executive leaders reported they implemented several strategies to strengthen communication, such as holding frequent virtual town halls and daily huddles (quick check-ins), sending regular all-employee emails, and participating in service-level meetings and leader rounds (visits to work areas throughout the facility). Leaders stated town halls were generally well attended, and employees provided positive feedback about ongoing communications. At the time of the inspection in February 2026, leaders were redeveloping the employee engagement committee and revitalizing the local employee recognition program.

Veteran Experiences

Although the OIG team found the facility's VSignals trust score (93 percent) was slightly below the VHA average (94 percent) in FY 2025, the score still indicates that veterans trust the facility and have confidence in the care provided.[16] Leaders reported they shared the scores with employees through service-level meetings and monthly town halls.

In an OIG questionnaire, patient advocates identified care coordination and difficulty reaching community care employees by phone as veterans' most common complaints. Leaders explained the difficulties reaching community care employees were related to overall staffing issues, and they have requested administrative assistance from the Veterans Integrated Service Network (VISN) Clinical Resource Hub.[17] Leaders also acknowledged inconsistent communication with

[16] Veteran trust in VA represents the percentage of respondents that strongly agree or agree to the statement "I trust VA to fulfill our country's commitment to Veterans." "About," VA, last updated March 27, 2026, https://department.va.gov/veteran-trust-in-va.

[17] Veterans Integrated Service Networks (VISNs) are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/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 are VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

patient advocates and planned monthly meetings with them to provide updates on changes in veterans' services.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[18] 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.[19]

General Inspection

At the medical center, the OIG team observed ample parking, including a designated accessible lot for individuals with disabilities. Transportation options included public bus routes and an on-site, volunteer-operated shuttle service.

The main entrance featured a covered passenger drop-off zone, power-assisted doors, and clear exterior signs. Information desk staff provided directions, offered wheelchairs, and transported veterans to their destinations.

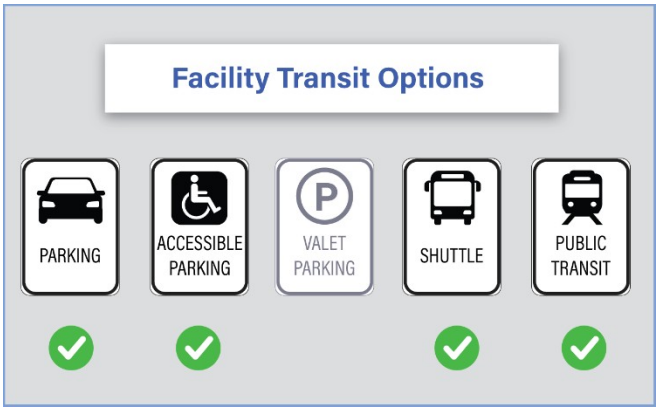

Figure 2. *Transit options for arriving at the facility. Source: OIG team observations.*

Accessibility tools were available throughout the facility, including braille, large-print fonts, assistive listening devices, translation services, and closed captioning. Inspectors also observed signs to guide veterans to their destinations, including large directional markers and wall maps

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

[19] 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.

that identified department locations. The OIG team found patient care areas to be generally clean and safe, with no apparent infection risks or privacy concerns.

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 reviewed the facility's service-level workflows (which outline staff roles in the communication process) and its policy for test result communications.[20] The team found the facility did not have written workflows for all services that communicate results to patients. Additionally, the policy did not include a process for assigning a designee (surrogate) when a provider is unavailable or leaves the facility. Both requirements must be in writing per VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[21]

Executive and facility leaders stated providers have designees to receive notifications of test results; however, they could not provide documentation of the process they use to assign a designee. Documenting the workflows and surrogate process supports prompt, effective clinical follow-up.

Recommendation 1

The Director develops workflows for all services that communicate test results to patients and includes the process for assigning designees (surrogates) for providers who order tests in the facility's policy, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients.*

__X__ Concur

_____ Nonconcur

Target date for completion: Completed

[20] New Mexico VA Health Care System, Medical Center Policy 11-64(1), *Test Result Communication: Critical and Non-Critical Test Results*, February 2026.

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

Director Comments

The New Mexico VA Healthcare System (NMVAHCS) Chief of Staff, Chief of Pathology and Laboratory Management Service, Chief of Primary Care, Chief of Radiology, Chief of Vascular and Chief of Cardiology reviewed VHA Directive 1088(1), Communicating Test Results to Providers and Patients, and Medical Center Policy (MCP) 11-64, Test Results Communication: Critical and Non-Critical Test Results. MCP 11-64 was updated to reflect a description of how staff delegate responsibility to communicate test results to patients as well as the service-level workflows.

On May 19, 2026, MCP 11-64 was signed by the Medical Center Director. On May 20, 2026, the NMVAHCS Policy Manager disseminated MCP 11-64 to all Service Chiefs, Medical Staff, Chief Nurses and Chief Nurse Managers. On June 18, 2026, MCP 11-64 was also shared with NMVAHCS Clinical Executive Board. On June 22, 2026, MCP 11-64 was also disseminated to NMVAHCS Quality Council. The revised MCP 11-64 is also published on the NMVAHCS Policy SharePoint.

The NMVAHCS System recommends closure of this recommendation prior to publication.

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) also requires VA medical facility providers who order tests or their designees to communicate all results requiring action to patients within 7 calendar days of the date they become available. For test results that do not require action, VHA requires the providers to communicate results within 14 calendar days of availability.[22] Facility leaders described meeting these requirements through a process where facility staff generate automated test result notification letters, which they review, sign, and mail to patients within 3 to 5 business days.

Action Plans and Process Improvements

The OIG team did not identify any previous findings related to communication of test results in the most recent OIG comprehensive healthcare inspection or Joint Commission reports.[23] The team found that leaders strengthened patient safety oversight through process improvements,

[22] VHA Directive 1088(1).

[23] VA OIG, *Comprehensive Healthcare Inspection of the New Mexico VA Health Care System in Albuquerque*, Report No. 22-00046-126, June 7, 2023; The Joint Commission, *Final Accreditation Report New Mexico VA Health Care System*, *Hospital, Behavioral Health Care and Human Services*, *Home Care*, March 24, 2023; The Joint Commission, *Final Accreditation Report New Mexico VA Health Care System*, *Laboratory*, May 1, 2024.

such as using a tracker to improve the visibility of open (unimplemented) recommendations and timeliness in closing recommendations.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[24] 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

In an interview, primary care leaders reported vacancies for seven providers, four registered nurses, and one licensed practical nurse, which they attributed to promotions, retirements, and transfers. The positions were in various stages of the hiring process, with several candidates awaiting start dates. However, the leaders also cited a statewide shortage of medical professionals, rural clinic locations, lengthy onboarding processes, and noncompetitive pay as barriers to filling positions. In response, they offered incentives such as student loan repayment and worked with a physician recruiter to identify candidates. The leaders managed vacancies with Clinical Resource Hub, contract, and fee-basis providers (who deliver specific services when full-time VA employees are not available), while some primary care staff supported more than one team.

The OIG team reviewed facility data and found new patient wait times increased from 24 days in quarter one of FY 2025 to 31 days in quarter one of FY 2026. Veterans may be eligible to receive community care when VA primary care wait times exceed 20 days, according to the Code of Federal Regulations (title 38, section 17.4040).[25] Primary care leaders attributed the increased wait times to staffing vacancies and veterans' preferences to schedule appointments beyond 20 days, despite being offered appointments sooner.

Leaders described meeting weekly with VISN staff to identify and implement strategies to improve access and increase efficiency. In October 2025, primary care leaders started increasing bookable hours (the time a provider is available to see patients) to make more appointments

[24] "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.

[25] 38 C.F.R. § 17.4040 (2025).

available; they also revised staff's schedules to ensure they offered the right type of care (face-to-face, telephone, or telehealth) at the right time.

Increased staffing levels and improved scheduling should help expand access to primary care and support earlier evaluation and treatment for veterans. Because of leaders' ongoing efforts to address these issues, the OIG did not make a recommendation.

Community Care Staffing and Access to Care

Community care leaders said recruitment for three medical support assistants and four registered nurses was in various stages of the process at the time of the inspection in February 2026. The leaders attributed vacancies to promotions, retirements, and the return to in-person work requirement.

The OIG found that most referrals to community providers were for dental services, complementary and integrative health (services such as medical massage and yoga), and radiology (the use of radiant energy such as x-rays to diagnose and treat disease). As of February 2026, community care staff averaged 39 days to schedule veterans' appointments, which exceeded the requirement in VHA's *Consult Timeliness Standard Operating Procedure* to schedule them within 7 days.[26] Leaders explained that high referral volumes and limited numbers of specialty care providers in the community contributed to delays. To improve timeliness, leaders approved overtime, coordinated with the company that manages the community care provider network to identify available providers, and referred veterans to other VHA facilities when possible.

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

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

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 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)."[29]

Performance and Improvement Highlights

- The facility did not meet the discharge to permanent housing (HCHV1) or negative exit (HCHV2) targets for FY 2025. Facility program staff said they had difficulties finding permanent housing within veterans' short-term stays in transitional housing, partly due to limited affordable housing in the service area. Also, many veterans were ineligible for HUD-VASH because of prior convictions. In addition, some veterans left before completing the program, which counts as a negative exit.
- To address veterans' needs, program staff operated a walk-in clinic that connected veterans to resources, and the facility's homeless primary care team provided health care with same-day access during the week.
- Program staff also said they partner with a local food bank to host a monthly mobile food pantry for veterans and others. In 2025, they held 12 events and served 4,253 individuals. In October 2025, the program opened a food pantry at the medical center that offered shelf-stable, ready-to-eat food for veterans experiencing food insecurity.
- However, staff identified external barriers that directly affect access to care and staff safety, including severe weather and long travel times to rural areas with

[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 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

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

unpaved roads. Rural areas also lacked resources and infrastructure, including internet, cell service, and public transportation.

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]

Performance and Improvement Highlights

- The facility did not meet the voucher use (HMLS3) target for FY 2024 but did for FY 2025. Facility program staff explained that in July 2024, staff began completing assessments and scheduling program orientation during each veteran's first meeting to ensure enrollment and engage them in the next steps of the program. Additionally, program leaders created a housing team dedicated to orientation, admission, and locating housing to reduce placement delays.
- The facility did not meet the employment (VASH3) target for FY 2025. Staff stated the shortfall was partly because they did not enter veterans' employment status in the program database, an issue they have now corrected through training. There was also no process to ensure veterans met with the employment specialist. Staff now schedule veterans with employment services during program orientation.
- Staff reported building partnerships with community organizations that help with rental deposits, utilities, furniture, gasoline, car repairs, hotels, towels, bedding, and pet kennels when veterans stay in shelters.
- However, staff said vacancies and position eliminations had a negative impact on operations, and they sometimes worked more than 40 hours weekly to meet

[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 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

veterans' needs. Additionally, most program positions were entry-level, leading to turnover as staff advanced in their careers. Promotion opportunities were limited because leaders eliminated two senior social worker positions.

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 met the enrollment (VJP1) target for FY 2025. Facility program staff attributed this success to increased referrals from new veteran treatment courts (a court model that provides judicially supervised treatment and services) and community partners.[35] These referrals resulted from staff outreach efforts, including visiting public defenders, judges, and probation offices; attending community events; and sending brochures to community partners.
- Staff work with veterans in treatment courts to connect them to VA and community services. They schedule appointments, coordinate treatment and medication management after release from custody, and report veterans' progress to probation offices, courts, and attorneys. These efforts aim to help veterans avoid previous problems or reoffending.
- However, staff identified staffing vacancies and lengthy wait times for facility appointments as challenges. Staff also had to travel long hours to rural areas, up to four hours one way, to meet veterans' needs.
- Staff also said the facility's behavioral health service could not care for additional veterans due to capacity, and rural clinics had insufficient behavioral specialists. To fill service gaps, staff started early-recovery skills groups and video-based bridge groups (which help veterans until they can transition into substance use disorder treatment programs).

[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.*

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

Conclusion

To assist leaders in evaluating the quality of care at the VA New Mexico Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to test result communications. The OIG's findings and recommendation 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 accreditation survey reports. 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 3 through 5, 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.[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.

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

[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.

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

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.

Appendix B: Health Service Area Director Comments

Department of Veterans Affairs Memorandum

Date: August 12, 2026

From: Health Service Area 5.3 Director, VISN 5

Subj: Healthcare Facility Inspection of the VA New Mexico Healthcare System in Albuquerque

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

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the OIG Draft Report-Health Care Facility Inspection of the VA New Mexico Healthcare System in Albuquerque. I have completed a full review of the draft report and concur with the recommendation provided by the VA Office of Inspector General.
2. I concur with the report and the action plan submitted by VA New Mexico Health Care System.
3. Please contact the VISN 5-Health Service Area 5.3 Quality Management Officer for questions or if additional information is needed.

(Original signed by:)

Walt Dannenberg, FACHE
Health Service Area 5.3 Director VISN 5

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 5, 2026

From: Director, VA New Mexico Healthcare System in Albuquerque (501)

Subj: Healthcare Facility Inspection of the VA New Mexico Healthcare System in Albuquerque

To: Director, Health Service Area 5.3, VISN 5

1. We appreciate the opportunity to review and comment on the VAOIG Draft Report—Healthcare Facility Inspection of the VA New Mexico Healthcare System. VA New Mexico Healthcare System concurs with the recommendation and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Interim Chief of Quality Management & Patient Safety.

(Original signed by:)

Michael Welsh, MD, RD
Interim Medical Center 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.