



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

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inspection of Select Vet Centers in North Atlantic District 1 Zone 2

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Report Overview

The purpose of the VA Office of Inspector General (OIG) Vet Center Inspection Program is to provide a focused evaluation of the quality of care delivered at vet centers. Vet centers are community-based facilities that offer a wide range of psychosocial services to clients, including eligible veterans, to support a successful transition from military to civilian life.¹

Vet center inspections are one element of the OIG's oversight to ensure the nation's veterans receive high-quality and timely mental health care and VA services. The inspections evaluate key clinical and administrative processes associated with promoting quality care and service delivery at vet centers as set forth by Veterans Health Administration (VHA) Directive 1500(4), *Readjustment Counseling Service (RCS)*.²

The OIG announced the inspection to district leaders on June 9, 2025, and conducted subsequent on-site and virtual visits from June 10 through July 24, 2025. The inspection also included a retroactive review of vet center operations from October 1, 2023, through September 30, 2024. The OIG randomly selected three vet centers throughout North Atlantic District 1 zone 2: Buffalo, Nassau, and Syracuse, New York.³

The inspection included four review areas:

- Suicide prevention
- Consultation, supervision, and training
- Outreach
- Environment of care

The findings presented in this report are a snapshot of the selected vet centers' performance within the identified review areas at the time of the OIG's inspection. The findings should help

¹ To be consistent with Readjustment Counseling Service (RCS) policy and terminology, the OIG refers to veterans receiving readjustment services as *clients* in this report.

² VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, was in effect during part of the OIG's inspection period. It was replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. This directive was replaced by VHA Directive 1500(5), *Readjustment Counseling Service*, January 26, 2021, amended March 3, 2025. Unless otherwise specified, the requirements in the directives contain the same or similar language. As a result, the OIG references VHA Directive 1500(4) throughout this report. Vet centers provide counseling for readjustment concerns related to specific types of military deployment stressors. "Readjustment counseling services are designed by law to be provided without a medical diagnosis." Therefore, individuals receiving readjustment services are not considered patients.

³ RCS is divided into five districts. Each district consists of two to four zones. Each zone consists of 16 to 24 vet centers.

vet centers to identify areas of vulnerability or conditions that if addressed could improve safety, accessibility, and quality of care.

Review Topics and Inspection Results

Suicide Prevention

The OIG found the Buffalo Vet Center Director (VCD) did not have a licensed provider attend the supporting VA medical facility's mental health executive council meetings as required by VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service* and VHA Directive 1500(4).⁴ Staff at all three vet centers documented all client contacts and outcomes in the [high risk suicide flag \(HRSF\) SharePoint site](#) as required by Chief Officer, Readjustment Counseling Services, "High Risk Suicide Flag Outreach," memorandum to all vet center staff.⁵

The OIG issued one recommendation to district leaders and the Buffalo VCD specific to suicide prevention activities.

Consultation, Supervision, and Training

As required by VHA Directive 1500(4), the OIG found that although external clinical consultation for clinically complex cases occurred at all three vet centers, none of the VCDs ensured completion of at least four hours of consultation per month.⁶ Staff at all three vet centers

⁴ VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023, contains a mental health executive council requirement with a purpose focused on ensuring "the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans' preferences"; VHA Directive 1500(4). RCS requires a licensed vet center staff member to participate on all supporting VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

⁵ On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; Chief Officer, Readjustment Counseling Services, "High Risk Suicide Flag Outreach," memorandum to all vet center staff, April 27, 2020. RCS staff confirmed as of June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health Veterans Enhanced Treatment (REACH VET) data. VA's REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide; The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

⁶ VHA Directive 1500(4).

did not complete select required training related to suicide prevention, lethal means, military sexual trauma, and basic life support.⁷

The OIG issued two recommendations to district leaders and the Buffalo, Nassau, and Syracuse VCDs specific to completion of four hours of monthly external clinical consultation and training of counselors.

Outreach

The OIG found all three vet centers had [outreach plans](#) to engage eligible veterans and their families and promote relationships with community partners and stakeholders. However, each plan lacked one or more required strategic components required by VHA Directive 1500(4).⁸ The Syracuse VCD provided an updated outreach plan containing all required components; therefore, a recommendation was not made for this vet center.

The OIG issued one recommendation to district leaders and the Buffalo and Nassau VCDs specific to outreach plans containing all required components.

Environment of Care

The OIG reviewed the requirements identified in the RCS, *Administrative Site Visit (ASV) Protocol* and found

- the Syracuse Vet Center did not have
 - an annual risk and vulnerability assessment completed by VA police or local law enforcement,
 - monthly fire extinguisher inspections,

⁷ VA Secretary, “Agency-Wide Required Suicide Prevention Training,” memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022; Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Lethal Means Safety (LMS) Education and Counseling,” memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), March 17, 2022; VHA Directive 1115.01(1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1115.01(1), *Military Sexual Trauma Mandatory Training Requirements*, July 15, 2024, amended March 7, 2025; VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021.

⁸ VHA Directive 1500(4). Required strategic components include: a strategic map of the vet center veterans service area identifying eligible population concentrations; strategic coordination with mobile vet center operations; background information of the local eligible communities; personal points of contact for non-VA service providers; and strategic VA medical facility partners including clinical and administrative liaisons, the external clinical consultant, the suicide prevention coordinator, and the facility contact for the prevention and management of disruptive behavior coordinator. RCS requires the outreach activities to be tailored to eligible individuals.

- annual servicing of all fire extinguishers,
- an automated external defibrillator (AED) inspected monthly and serviced annually by VA medical center biomedical engineering, and
- all required components in the emergency and crisis plan; and
- the Nassau Vet Center did not have all required components in the emergency and crisis plan.⁹

At the time of the inspection, the OIG found Syracuse vet centers did not have VA police or local law enforcement complete an annual risk and vulnerability assessments.¹⁰ In early 2025, the OIG identified inconsistency between the RCS administrative site visit protocol requirement for an annual risk and vulnerability assessment and VA police guidance and issued a recommendation related to assessment frequency to the RCS Chief Officer.¹¹ Subsequently, in October 2025, RCS eliminated the annual requirement and aligned risk and vulnerability assessment frequency with VHA policy; therefore, the OIG did not make a recommendation.

The OIG issued five recommendations to district leaders and the Nassau and Syracuse VCDs specific to environment of care.

Additional Findings

The OIG found that unclear roles and oversight responsibilities for RCS leaders, insufficient staff training, and the absence of standardized policies related to the relocation of the Buffalo Vet Center created obstacles that negatively affected client access to care.

The OIG made one recommendation to district leaders specific to discrepancies in the vet center address on VA and public-facing websites.

⁹ RCS, *Administrative Site Visit (ASV) Protocol*. Vet centers are required to have a fire or safety inspection and a risk and vulnerability assessment annually. The risk and vulnerability assessment must be completed by VA police or local law enforcement. Vet centers must also have fire extinguishers and AED available for staff, both requiring annual servicing and monthly inspections to ensure proper functioning. RCS requires vet centers to have a current emergency and crisis plan that includes contingencies for the following: phone and computer disruptions; weather and natural disasters; site, facility, and building emergencies; site, facility, and building temporary relocation; management of disruptive behavior; violence in the workplace, including active shooter plan; and handling of suspicious mail and bomb threats. Additionally, RCS requires the posting of a building evacuation plan in a common area for staff and visitors to reference in case of an emergency.

¹⁰ RCS, *ASV Protocol*.

¹¹ VA OIG, [Inspection of Select Vet Centers in Midwest District 3 Zone 1](#), Report No. 24-00393-180, August 5, 2025. On October 6, 2025, the RCS Office of Policy and Oversight implemented a new vet center quality review protocol, which combines the administrative and clinical site visits and aligns risk and vulnerability assessment frequency with VHA policy.

Conclusion

The OIG conducted a focused inspection in four review areas and made 10 recommendations to the District Director and the Buffalo, Nassau, and Syracuse VCDs. These recommendations are intended to be used as a road map to help improve operations and clinical care. The recommendations address systems' issues and site-specific findings that may compromise quality care.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

On February 9, 2026, the Chief Readjustment Counseling Officer and District Director concurred with the findings and recommendations and provided an acceptable action plan (see appendixes B and C). District leaders reviewed requirements and developed plans for participation in VA mental health executive council, external clinical consultation, outreach plans, and emergency and crisis plans with VCDs. Further, district leaders developed processes to ensure staff complete training, fire extinguishers and AEDs are serviced as required, and to update public-facing websites. Based on information provided, the OIG considers recommendations 1 and 4–7 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.



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Abbreviations

AED	automated external defibrillator
BLS	basic life support
HRSF	high risk suicide flag
OIG	Office of Inspector General
RCS	Readjustment Counseling Service
VCD	vet center director
VHA	Veterans Health Administration



Introduction

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The VA Office of Inspector General (OIG) reviews available evidence within a specified scope and methodology and makes recommendations to VA leadership if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

The purpose of the OIG Vet Center Inspection Program is to conduct oversight of vet centers that provide readjustment services to clients.¹ The OIG reports findings to Congress and Readjustment Counseling Service (RCS) leaders so informed decisions can be made to improve care.

RCS is an autonomous organizational element in the Veterans Health Administration (VHA) with authority for and oversight of vet centers and the provision of readjustment counseling services. Vet centers are community-based facilities that provide a wide range of psychosocial services to clients to support a successful transition from military to civilian life.²

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

The OIG is aware of VA’s transformation in VHA’s management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

¹ VHA Directive 1500(3), *Readjustment Counseling Service*, January 26, 2021, amended June 5, 2023, was in effect during part of the OIG’s inspection period. It was replaced by VHA Directive 1500(4), *Readjustment Counseling Service*, January 26, 2021, amended November 21, 2023. This directive was replaced by VHA Directive 1500(5), *Readjustment Counseling Service*, January 26, 2021, amended March 3, 2025. Unless otherwise specified, the requirements in the directives contain the same or similar language. As a result, the OIG references VHA Directive 1500(4) throughout this report. Vet centers provide counseling for readjustment concerns related to specific types of military deployment stressors. According to VHA Directive 1500(4), “readjustment counseling services are designed by law to be provided without a medical diagnosis.” Therefore, individuals receiving readjustment services are not considered patients. To be consistent with Readjustment Counseling Service (RCS) policy and terminology, the OIG refers to veterans receiving readjustment services as *clients* in this report.

² VHA Directive 1500(4). Vet center counselors provide readjustment counseling to assist clients with psychological and psychosocial readjustment.

Scope and Methodology

The OIG randomly selected district 1 and the following three vet centers in zone 2 for review: Buffalo, Nassau, and Syracuse, New York (see figure 1).³

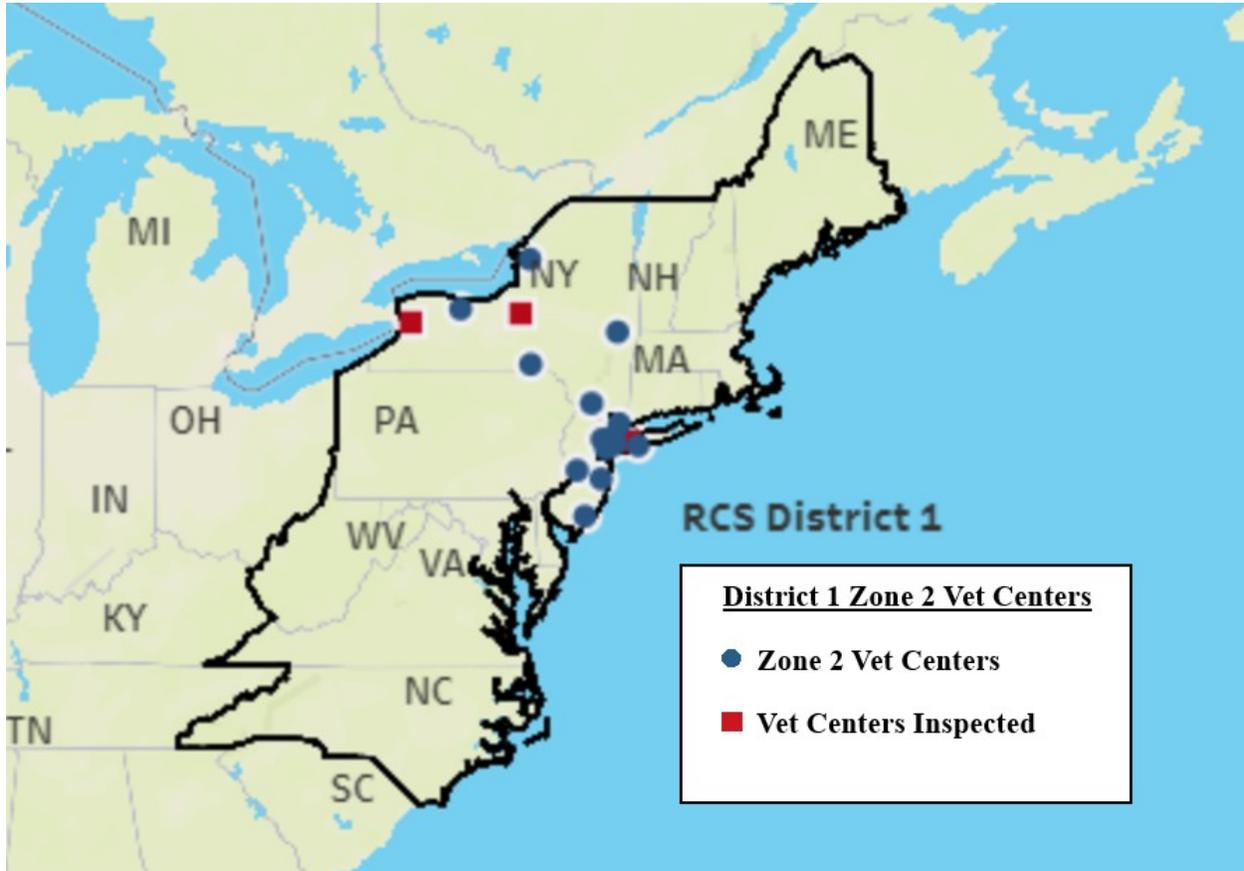


Figure 1. Map of North Atlantic District 1 zone 2 vet centers, including sites visited by the OIG.
Source: The OIG using RCS vet center data.

The OIG announced the inspection to district leaders on June 9, 2025, and conducted subsequent on-site and virtual visits from June 10 through July 24, 2025.⁴ The OIG inspection included a retroactive review of vet center operations from October 1, 2023, through September 30, 2024, in the following categories:⁵

³ RCS is divided into five districts. Each district consists of two to four zones. Each zone consists of 16 to 24 vet centers.

⁴ For the purposes of this report, the term “district leaders” refers to a combination of two or more of the following: district director, deputy district director, associate district director for counseling, and associate district director for administration.

⁵ The OIG review period was from October 1, 2023, through September 30, 2024, (fiscal year 2024) unless otherwise noted.

- Suicide prevention
- Consultation, supervision, and training
- Outreach
- Environment of care

The OIG notified each selected vet center director (VCD) one day prior to the site visit. During the site visits, the inspection team interviewed VCDs and key staff and reviewed RCS practices and policies.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

Overall Findings

The OIG reviewed VHA and RCS requirements and below are the inspection findings for the three selected vet centers. For additional details related to specific site findings, select the vet center in the respective review table.

Suicide Prevention

Early identification of clients at high risk for suicide allows for the provision of enhanced services and may prevent ongoing suicidality.⁶ In an effort to reduce client risk for suicide and enhance care, each vet center aligns with a supporting VA medical facility.⁷ According to VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service* and VHA Directive 1500(4), *Readjustment Counseling Service*, VHA and RCS staff members are required to participate in the supporting VA medical facility's mental health executive council meetings to coordinate the care of shared clients.⁸

The [high risk suicide flag \(HRSF\) SharePoint site](#) is part of an RCS national process intended to increase communication and coordination with VHA to ensure identification of clients at risk for

⁶ VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*, November 1, 2020.

⁷ VHA Directive 1500(4). Each vet center aligns with a supporting VA medical facility to ensure access to clinical services and coordination of care for shared clients.

⁸ VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023, contains the mental health executive council requirement with a purpose focused on ensuring “the delivery of high-quality Veteran mental health care that is evidence-based and responsive to Veterans’ preferences”; VHA Directive 1500(4). RCS requires a licensed vet center staff member participate on all supporting VA medical facility mental health executive council meetings to assist with care coordination and collaboration for clients.

suicide and provide resources that may reduce client risk as required by Chief Officer, Readjustment Counseling Services, “High Risk Suicide Flag Outreach,” memorandum.⁹

Table 1. Suicide Prevention Results

 Compliant  Noncompliant RCS Requirement	Buffalo Vet Center (supported by VA Western New York Healthcare System)	Nassau Vet Center (supported by Northport VA Medical Center)	Syracuse Vet Center (supported by Syracuse VA Medical Center)
A licensed vet center staff member participates in all supporting VA medical facility mental health executive council meetings.*			
VCD ensures client contacts and outcomes are documented in the HRSF SharePoint site.‡			

Sources: VHA Directive 1500(4); VA Chief Officer, Readjustment Counseling Service (10RCS); OIG analysis of vet center data.

*The OIG reviewed mental health executive council meeting documentation to evaluate if required vet center staff participated in the meeting.

‡The OIG reviewed client contacts and outcomes in the HRSF SharePoint site from June 2024 to September 2024.

The OIG found that staff at all three vet centers documented client contacts and outcomes in the HRSF SharePoint site.

In the identified area, the VCD reported the following explanation for noncompliance.

- *Mental health executive council participation:* The Buffalo VCD was aware of the requirement to attend all mental health executive council meetings but felt the meetings were not beneficial for vet centers and thus opted not to attend.

The OIG made one recommendation related to suicide prevention.

⁹ On May 11, 2020, RCS implemented a HRSF SharePoint site containing names of RCS clients who also receive services at a VA medical facility and have a high risk for suicide flag; Chief Officer, Readjustment Counseling Services, “High Risk Suicide Flag Outreach,” memorandum to all vet center staff, April 27, 2020. RCS staff confirmed as of June 2021, the SharePoint site was expanded to include Recovery Engagement and Coordination for Health-Veterans Enhanced Treatment (REACH VET) data. VA’s REACH VET is a predictive analytics program developed to determine veterans who have a higher risk for suicide; The underlined terms are hyperlinks to additional information. To return from the linked information, press and hold the “alt” and “left arrow” keys together.

Suicide Prevention Recommendation

Recommendation 1

District leaders and the Buffalo Vet Center Director collaborate with the supporting VA medical facility to determine reasons for noncompliance with staff participation in the mental health executive council, take action as indicated, and monitor compliance.

Consultation, Supervision, and Training

As required by VHA Directive 1500(4), consultation with an [independently licensed mental health external clinical consultant](#) on clinically complex or high risk cases improves client access to VA health care and ensures that counselors receive supervision through ongoing feedback regarding documentation, case planning, and compliance with RCS guidance and procedures.¹⁰ Mandatory training completion supports a competent and skilled staff to provide services to clients.¹¹

Reviewed training included

- Nonclinical staff
 - Initial or annual S.A.V.E. training [**S**igns of suicide, **A**sk about suicide, **V**alidate feelings, and **E**ncourage seeking help and **E**xpedited treatment] (as required by VA Secretary, “Agency-Wide Required Suicide Prevention Training,” memorandum and VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*)¹²
- Clinical Staff
 - Initial or annual suicide risk management training (as required by the VA Secretary, “Agency-Wide Required Suicide Prevention Training,” memorandum)¹³
 - One-time lethal means safety education and counseling (as required by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer

¹⁰ VHA Directive 1500(4).

¹¹ VHA Directive 1052, *Appropriate and Effective Use of VHA Employee Mandatory and Required Training*, June 29, 2018.

¹² VA Secretary, “Agency-Wide Required Suicide Prevention Training,” memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 15, 2020; VHA Directive 1071(1), *Mandatory Suicide Risk and Intervention Training*, May 11, 2022, amended June 21, 2022. Vet center nonclinical staff include a veterans outreach program specialist and program support assistant or office manager.

¹³ VA Secretary, “Agency-Wide Required Suicide Prevention Training,” memorandum; Skills training for evaluation and management of suicide completion is required within 90 days of hire for new clinical providers and annually for current clinical providers. VHA considers clinical staff to include psychologists, social workers, case managers, and vet center counselors; VHA Directive 1071(1).

(CMO), “Lethal Means Safety (LMS) Education and Counseling,” memorandum)¹⁴

- One-time military sexual trauma training (as required by VHA Directive 1115.01 (1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*)¹⁵
- All staff
 - Biannual basic life support (BLS) certification (as required VHA Directive 1177, *Cardiopulmonary Resuscitation*)¹⁶

¹⁴ Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer (CMO), “Lethal Means Safety (LMS) Education and Counseling,” memorandum to Veterans Integrated Services Network (VISN) Director (10N1-23), Medical Center Directors (00), VISN CMOs (10N1-23), VISN Chief Mental Health Officers (10N1-23), Readjustment Counseling Services (RCS) District Directors, RCS Deputy District Directors VISN CMOs (10N1-23), March 17, 2022. Lethal Means Safety Education and Counseling training completion is required within 90 days of entering the position for new clinical providers or within 90 days of training assignment for current clinical providers.

¹⁵ VHA Directive 1115.01(1), *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017, amended May 8, 2020. This directive was in place during the time of the events discussed in this report. It was rescinded and replaced by VHA Directive 1115.01(1), *Military Sexual Trauma Mandatory Training Requirements*, July 15, 2024, amended March 7, 2025. The two directives contain the same or similar requirements for training. Military sexual trauma training completion is required within 90 days of entering the position for clinical providers or “a provider must have completed the assigned training program (or passed the test-out, if applicable) in TMS [Talent Management System], or have time remaining until the assignment due date.”

¹⁶ VHA Directive 1177, *Cardiopulmonary Resuscitation*, January 4, 2021. Any VA healthcare provider actively participating in direct patient care must maintain BLS training. The OIG was informed by an RCS leader that all RCS staff are required to complete BLS training biannually.

Table 2. Consultation, Supervision, and Training Results

 Compliant  Noncompliant RCS Requirement	Buffalo Vet Center	Nassau Vet Center	Syracuse Vet Center
Consultation: Assignment of a clinical liaison .			
Consultation: Assignment of an independently licensed mental health external clinical consultant.			
Consultation: Completion of four hours of monthly external clinical consultation for clinically complex cases.			
Supervision: VCD monthly review of 10 percent of active client records for each counselor’s caseload.			
Training: Staff completion of select trainings in the required time frame.*			

Sources: VHA Directive 1500(4); VHA Directive 1115.01(1); VHA Memorandum, “Lethal Means Safety (LMS) Education and Counseling”; VA Memorandum, “Agency-Wide Required Suicide Prevention Training”; VHA Directive 1071; OIG analysis of vet center results.

*The OIG reviewed training records or BLS card copies and had findings with recommendations if one or more training elements were not completed within the required time frame. The OIG evaluated BLS training for all staff and evaluated annual training requirements for staff who had been employed prior to July 1, 2024. The OIG evaluated timeliness for completion of initial training for staff hired between October 1, 2023, and June 30, 2024.

The OIG found all three vet centers had an assigned clinical liaison and independently licensed mental health external clinical consultant. Additionally, all three VCDs completed a monthly review of 10 percent of active client records for each counselor’s caseload.

In identified areas, the VCDs reported the following explanations for noncompliance.

- *Completion of required four hours of monthly external clinical consultation:* The Buffalo VCD was aware of the requirement but did not reschedule missed meetings due to poor planning and conflicting priorities. The Nassau VCD was not in the role for the first three months of the review period and could not speak to missed meetings during that time. The remaining missed meetings either fell on federal holidays or days the external clinical consultant was on leave and were not rescheduled due to the VCD not having guidance on the need to reschedule

meetings. The Syracuse VCD held consultation meetings monthly but was unable to recall why four hours of consultation did not occur for some months due to the time that had passed. Occasionally meetings did not last a full hour resulting in less than the required four hours of consultation; however, in these circumstances, the VCD felt the requirement was met.

- *Completion of select staff training:* The Buffalo VCD was aware of training requirements but was unsure who was responsible for training assignments. The Buffalo VCD also asked for a list of required training for vet center staff from district leaders to streamline training reviews, but was told the list was inaccurate and found the whole training oversight process ineffective. The Nassau VCD stated that RCS leaders had not assigned courses in the training application; therefore, was unaware the trainings were due. The Syracuse VCD infrequently reviewed staff training completion due to it being a labor-intensive task. The Syracuse VCD was also unaware what specific trainings were required for military sexual trauma.

The OIG made two recommendations related to consultation, supervision, and training.

Consultation, Supervision, and Training Recommendations

Recommendation 2

District leaders and the Buffalo, Nassau, and Syracuse Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented to complete consultation requirements, and monitor compliance.

Recommendation 3

District leaders and the Buffalo, Nassau, and Syracuse Vet Center Directors determine reasons for noncompliance with employees completing select training in the required time frame, ensure completion, and monitor compliance.

Outreach

As required by VHA Directive 1500(4), each vet center must have an annual written [outreach plan](#) that identifies events to engage eligible veterans and their families and promote relationships with community partners and stakeholders.¹⁷

¹⁷ VHA Directive 1500(4).

Table 3. Outreach Results

 Compliant  Noncompliant RCS Requirement	<u>Buffalo Vet Center</u>	<u>Nassau Vet Center</u>	<u>Syracuse Vet Center</u>
Presence of a written current <u>outreach plan</u> .			
Inclusion of required outreach plan strategic components.*			 ‡
Outreach activities tailored to eligible individuals.			

Sources: VHA Directive 1500(4); OIG analysis of vet center results.

*The OIG reviewed outreach plan requirements including a strategic map of the vet center service area identifying eligible population concentrations, strategic coordination with mobile vet center operations, personal points of contact for non-VA service providers, and identification of all strategic VA medical facility partners.

‡The Syracuse Vet Center’s outreach plan did not contain all the required strategic components. However, the VCD provided an updated outreach plan that included all required components; therefore, the OIG did not make a recommendation.

The OIG found all three vet centers had an outreach plan with activities tailored to eligible individuals in the vet center service area.¹⁸

In the identified area, the VCDs reported the following explanations for noncompliance.

- *Inclusion of required strategic components:* The Buffalo VCD had not reviewed policy related to outreach plans and was not aware of requirements. The Nassau VCD did not receive any formal outreach training and was unaware of outreach plan requirements. The Syracuse VCD used the 2024 outreach plan template provided by the district and was uncertain whether missing components resulted from staff not adding them or components not being included in the template. The Syracuse VCD provided an updated outreach plan for 2025 that included all required components; therefore, the OIG did not make a recommendation specific to the Syracuse VCD.

The OIG made one recommendation related to outreach.

¹⁸ VHA Directive 1500(4).

Outreach Recommendation

Recommendation 4

District leaders and the Buffalo and Nassau Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

Environment of Care

Safety in the physical environment is essential for promoting effective therapeutic work and requires adherence to general safety and emergency preparedness standards.¹⁹ The OIG reviewed the requirements in table 4 as set forth by the RCS, *Administrative Site Visit (ASV) Protocol*.

Table 4. Environment of Care Results

 Compliant  Noncompliant RCS Requirement	Buffalo Vet Center	Nassau Vet Center	Syracuse Vet Center
Fire or safety inspection completed annually.			
Risk and vulnerability assessment completed annually by VA police or local law enforcement.‡	NA*		
Fire extinguishers inspected monthly.			
Fire extinguishers serviced annually.			
Automated external defibrillator (AED) located on-site.			
AED inspected monthly.			

¹⁹ VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023. Unless otherwise specified, the requirements in the June 2021 directive contain the same or similar language as the amended September 2023 document. The OIG evaluated compliance of monthly inspections for fire extinguishers and AEDs by reviewing inspection documentation for the three full months prior to district notification. The OIG evaluated the presence of an AED and a building evacuation plan during on-site inspections.

 Compliant  Noncompliant RCS Requirement	<u>Buffalo Vet Center</u>	<u>Nassau Vet Center</u>	<u>Syracuse Vet Center</u>
AED serviced annually by VA medical center biomedical engineering.			
Building evacuation plan posted in communal area for staff and visitors to reference.			
Emergency and crisis plan with required components. [§]			

Sources: RCS, Administrative Site Visit Protocol; OIG analysis of vet center results.

*The Buffalo VCD was noncompliant with an annual risk and vulnerability assessment at the prior location. However, the VCD provided a 2025 assessment for the new vet center location; therefore, the OIG did not make a recommendation.

‡As of October 2025, RCS eliminated the annual requirement and aligned risk and vulnerability assessment frequency with VHA assessment timeliness.

§The OIG evaluated if the plan had been reviewed or updated within two years of the inspection date. The emergency and crisis plan includes contingencies for phone and computer disruptions; weather or natural disaster emergency plan; site, facility, or building temporary relocation plan; management of disruptive behavior plan; violence in the workplace plan (including active shooter plan); and handling of suspicious mail and bomb threats.

The OIG found all three vet centers had an annual fire or safety inspection, AEDs on-site, and a building evacuation plan posted in a communal area.

In identified areas, the VCDs reported the following explanations for noncompliance.

- **Risk and vulnerability assessment:** The Buffalo VCD was unaware of the annual requirement, did not remember receiving any training, and only learned of the requirement after being detailed to the acting Associate District Director for Administration role in March 2025.²⁰ The Buffalo VCD did provide a risk and vulnerability assessment from 2025 for the new vet center location. The Syracuse VCD provided an assessment completed by VA police in 2023 that noted the next assessment was due in five years. The VCD deferred to the VA police for the frequency of the assessment and was unaware that RCS requires the assessment annually.

²⁰ The Buffalo VCD was detailed to the district office as the Acting Associate District Director of Administration effective March 2025, with the detail expected to conclude in March 2026.

- *Fire extinguisher inspected monthly:* The Syracuse VCD noted the fire extinguisher that was not inspected was in an information technology closet that vet center staff do not routinely enter and lacked an oversight process to ensure monthly inspections.
- *Fire extinguishers serviced annually:* The Syracuse VCD noted the fire extinguisher that was not serviced annually was in an information technology closet that vet center staff do not routinely enter and lacked an oversight process to ensure annual servicing.
- *AED inspected monthly:* The Syracuse VCD ensured staff completed monthly inspections of the AED but did not document inspections for one month in the review period. The VCD identified the discrepancy in May 2025 and corrected it for future inspections.
- *AED serviced annually:* The Syracuse VCD was unaware of the requirement for VA medical center biomedical engineering to annually service the AED.
- *Emergency and crisis plan with all components:* The Nassau VCD believed the components included within the plan met requirements. The Syracuse VCD utilized a plan provided by the supporting VA medical center and believed this plan met requirements.

In early 2025, the OIG identified inconsistency between the RCS administrative site visit protocol requirement for an annual risk and vulnerability assessment and VA police guidance and issued a recommendation related to assessment frequency to the RCS Chief Officer.²¹ In October 2025, RCS updated risk and vulnerability assessment requirements to align with VHA assessment timelines and therefore, the OIG did not make a recommendation to the Syracuse Vet Center.

The OIG made five recommendations related to environment of care.

Environment of Care Recommendations

Recommendation 5

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

²¹ VA OIG, [Inspection of Select Vet Centers in Midwest District 3 Zone 1](#), Report No. 24-00393-180, August 5, 2025. On October 6, 2025, the RCS Office of Policy and Oversight implemented a new Vet Center Quality Review protocol, which combines the Administrative and Clinical Site Visits and aligns risk and vulnerability assessment frequency with VHA assessment timeliness.

Recommendation 6

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

Recommendation 7

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Recommendation 8

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

Recommendation 9

District leaders and the Nassau and Syracuse Vet Center Directors determine reasons for noncompliance with having an emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

Additional Findings for the Buffalo Vet Center

The OIG found that unclear roles and oversight responsibilities for RCS leaders, and the absence of standardized policies related to the relocation of the Buffalo Vet Center created obstacles that negatively affected client access to care.

According to VHA Directive 1500(4), RCS requires vet centers be in “leased space outside of, and apart from VA medical facilities, in easily accessible locations.” The VCD and deputy district director are responsible for selecting mission-appropriate sites for vet centers. The associate district director for administration and VCD are responsible for documentation related to relocation, expansion, and renegotiation of RCS leases.²²

The OIG found the following at the Buffalo Vet Center:

1. Inconsistent processes for viewing potential sites prior to lease signing.
2. Temporary locations used during the relocation did not meet client care needs.
3. Varying vet center addresses listed on websites such as RCS, VHA, and search engines nine months after the vet center relocated.

²² VHA Directive 1500(4).

4. A lack of RCS procedural guidance with oversight responsibilities for vet center closures and relocations.²³

Although district leaders and the VCD initiated the relocation process in 2016, a new lease was not signed until September 2023, and the VCD reported the vet center reopened at the new location in February 2025. According to an RCS leader and the VHA contracting officer, site surveys were completed for nine potential locations; however, no survey was completed for the selected site. Contrary to RCS policy requirements, the VCD reported not being involved in the site selection process and voiced concerns regarding clients' ability to access the new location due to traffic. The OIG could not confirm whether RCS staff toured the selected site prior to the lease signing due to conflicting accounts from the contracting officer and RCS leaders.

Furthermore, from September 2024 through February 2025, while the Buffalo Vet Center was relocating, staff reported lacking space for in-person client sessions due to delays in opening the new location. Although a mobile vet center was deployed to support service delivery, it could only accommodate one client session at a time. One counselor reported using public spaces such as local parks, libraries, and community access points as alternative meeting locations.²⁴ The OIG reviewed in-person client visit data when vet center staff provided services from alternate locations and identified a decline in volume. However, when the new location opened in February 2025, the in-person client visits increased (see figure 2). The Deputy District Director reported being unaware of the concerns related to the lack of space for in-person visits.

²³ An RCS leader provided the OIG a Relocation Process Summary document and reference to RCS policy for oversight responsibilities. The OIG reviewed the Relocation Process Summary document and RCS policy for oversight responsibilities and did not find the documents included process steps for the relocation, including temporary relocation, of a vet center to a new location or identify oversight responsibilities for RCS leaders during the closure and relocation process.

²⁴ A community access point (also referred to as a CAP) is a no-cost site established with a vet center community partner that hosts a vet center counselor who provides readjustment counseling on its premises on a regular recurring basis.

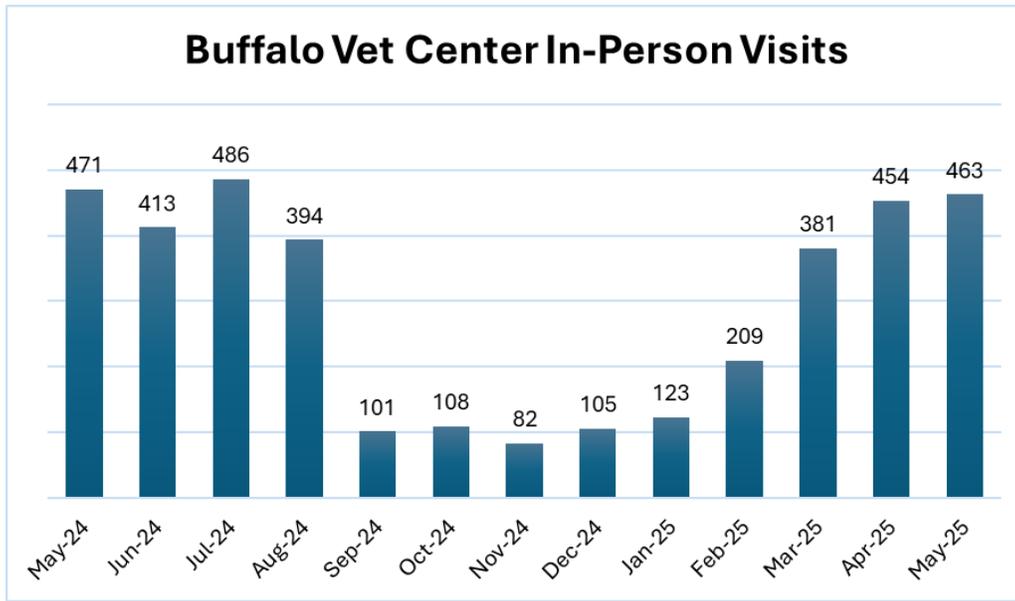


Figure 2. Buffalo Vet Center in-person client visit numbers depicting decline of in-person visits during the vet center closure from September 2024 – February 2025.
 Source: OIG using RCS vet center data.

Additionally, while preparing for the June 2025 on-site visit, the OIG identified discrepancies in the vet center address across various websites. The district leaders acknowledged the inconsistencies, noting similar issues had occurred at other vet center locations. The Associate District Director for Administration also reported there was no formal RCS guidance on how to correct these errors, further highlighting the lack of policy and guidance related to vet center relocations.

Ultimately, the relocation of a vet center without clearly defined roles and oversight responsibilities for RCS staff, combined with a lack of policies, relocation plans for client care, and updated vet center information, can create significant barriers to client access. These barriers may negatively affect clients’ mental health and lead to missed opportunities for timely intervention, including suicide prevention.

In May 2025, the OIG identified a lack of written guidance and oversight of vet center closures and relocations. At that time, the OIG issued the following recommendation to the RCS Chief Officer:

The Readjustment Counseling Service Chief Officer considers developing written guidance for vet center closure and temporary relocation processes including oversight responsibilities.

As of August 27, 2025, this recommendation remained open; therefore, the OIG will continue to monitor the progress and not make a new recommendation.²⁵

The OIG made one recommendation related to the additional findings.

Recommendation 10

District leaders determine reasons why there are discrepancies in the vet center address on VA and public-facing websites and ensure all websites include correct location information.

Conclusion

The OIG conducted a focused inspection in four review areas and made 10 recommendations to the District Director and the Buffalo, Nassau, and Syracuse VCDs related to staff participation in the mental health executive council, completion of four hours of monthly external clinical consultation, training of counselors, outreach plans containing all required components, completion of annual risk and vulnerability assessments, inspections and servicing of fire extinguishers and AEDs, emergency and crisis plans containing all required components, and accurate vet center location information on VA and public-facing websites.

In response, district leaders provided guidance to VCDs, and developed plans for participation in VA mental health executive council, external clinical consultation, outreach plans, and emergency and crisis plans with VCDs. Further, district leaders developed processes to ensure staff complete training, fire extinguishers and AEDs are serviced as required, and to update public-facing websites.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

²⁵ VA OIG, [Inspection of Select Vet Centers in Midwest District 3, Zone 2](#), Report No. 24-00394-122, May 27, 2025.

Appendix A

This section presents an overview of each selected vet center along with inspection results. For an overview of all results see [Overall Findings](#).

Buffalo Vet Center

The VCD reported the Buffalo Vet Center serves clients throughout four counties in New York: Niagara, Erie, Chautauqua, and Cattaraugus, and is supported by the VA Western New York Healthcare System. The VCD reported 66,910 eligible veterans reside in the veterans service area, which includes the Niagara Falls Air Reserve Station. The VCD highlighted the vet center staff for their resiliency during relocation, outreach to underserved populations, and strong relationships with local military units.

Table A.1. Fiscal Year 2024 Vet Center Profile

Profile	Buffalo Vet Center
Budget	\$1,587,174.29
Total Unique Clients	560
New Clients	152
Active Duty Clients	12
Bereavement Clients	11
Family Clients	96
Total Authorized Full-time Positions	10
Total Filled Positions	9
Total Vacancies	1

Source: RCS data.

For compliant element findings, please see findings related to [Suicide Prevention](#); [Consultation, Supervision, and Training](#); [Outreach](#); and [Environment of Care](#).

Identified Deficiencies

[Suicide Prevention](#)

Mental health executive council participation: Of the 11 meetings held in fiscal year 2024, the vet center had representation at six.

[Consultation, Supervision, and Training](#)

External clinical consultation hours: Four hours of external clinical consultation were not provided for all 12 months reviewed.

Staff training:

- Two of eight clinical staff did not complete suicide risk management training.
- One of nine staff did not complete the required BLS training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: personal points of contact for non-VA service providers and strategic VA medical facility partners.²⁶

Environment of Care

Risk and vulnerability assessment: VA police completed the most recent risk and vulnerability assessment at the prior vet center location in April 2022; however, the VCD provided a 2025 assessment for the new vet center location.

Additional Finding

The OIG found that the relocation process lacked clearly defined roles and oversight responsibilities for RCS leaders. Additionally, insufficient staff training, the absence of standardized policies, and outdated vet center information collectively created obstacles that negatively affected client access to care.

²⁶ Strategic VA medical facility partners did not include the administrative liaison, a suicide prevention coordinator, the facility contact for prevention and management of disruptive behavior, or the public affairs officer.

Nassau Vet Center

The VCD reported the Nassau Vet Center serves clients throughout Nassau County and is supported by the Northport VA Medical Center. The VCD reported 27,124 eligible veterans reside in the veterans service area, which does not include any military bases. The VCD highlighted the re-opening of the Nassau Vet Center after undergoing an expansion and partnering with a community organization to host a fishing trip for clients.

For compliant element findings, please see findings related to [Suicide](#)

[Prevention](#); [Consultation, Supervision, and Training](#); [Outreach](#); and [Environment of Care](#).

Table A.2. Fiscal Year 2024 Vet Center Profile

Profile	Nassau Vet Center
Budget	\$1,085,523.67
Total Unique Clients	347
New Clients	130
Active Duty Clients	14
Bereavement Clients	3
Family Clients	30
Total Authorized Full-time Positions	8
Total Filled Positions	8
Total Vacancies	0

Source: RCS data.

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 8 of the 12 months reviewed.

Staff training: One of four clinical staff did not complete suicide risk management training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: identification of VA medical facility partners and strategic coordination with mobile vet center operations.²⁷

Environment of Care

Emergency and crisis plan: The emergency and crisis plan did not include contingencies for phone and computer disruptions.

²⁷ Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Syracuse Vet Center

The VCD reported the Syracuse Vet Center serves clients throughout seven counties within New York: Cayuga, Madison, Oneida, Onondaga, Oswego, Seneca, and Wayne, and is supported by the Syracuse VA Medical Center.

The VCD reported 58,751 veterans reside in the veterans service area, which includes the 174th Attack Wing unit of the Air National Guard and NY Army National Guard's 27th Infantry Brigade Combat Teams. The VCD highlighted a variety of evidence-based groups offered by the vet center; including anger management and a women's group; and a strong

relationship with the Air National Guard, which has led to many referrals.

For compliant element findings, please see findings related to [Suicide Prevention](#); [Consultation, Supervision, and Training](#); [Outreach](#); and [Environment of Care](#).

Table A.3. Fiscal Year 2024 Vet Center Profile

Profile	Syracuse Vet Center
Budget	\$1,198,246.44
Total Unique Clients	390
New Clients	154
Active Duty Clients	65
Bereavement Clients	4
Family Clients	78
Total Authorized Full-time Positions	8
Total Filled Positions	7
Total Vacancies	1

Source: RCS data.

Identified Deficiencies

Consultation, Supervision, and Training

External clinical consultation hours: Four hours of external clinical consultation were not provided for 5 of the 12 months reviewed.

Staff training:

- One of six clinical staff did not complete military sexual trauma training.
- One of the eight staff members did not complete BLS training.

Outreach

Outreach plan: The outreach plan was missing two required strategic components: identification of VA medical facility partners and strategic coordination with mobile vet center operations.²⁸

²⁸ Strategic VA medical facility partners did not include clinical and administrative liaisons, an external clinical consultant, a suicide prevention coordinator, or the facility contact for prevention and management of disruptive behavior.

Environment of Care

Risk and vulnerability assessment: VA police completed the most recent risk and vulnerability assessment in March 2023.

Fire extinguisher inspection: Of the three months the OIG reviewed, one of three fire extinguishers was missing all inspections.

Fire extinguisher servicing: One of the three fire extinguishers was not serviced annually.

AED inspection: Of the three months the OIG reviewed, one monthly AED inspection was not completed.

AED servicing: VA medical center biomedical engineering did not service the AED annually.

Emergency and crisis plan: The emergency and crisis plan did not include contingencies for site or facility temporary relocation.

Appendix B: RCS Chief Readjustment Counseling Officer Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2026

From: Chief Officer, Readjustment Counseling Service (10RCS)

Subj: Inspection of Select Vet Centers in North Atlantic District 1 Zone 2

To: Director, Office of Healthcare Inspections, Vet Center Inspection Program (VC00)
Director, GAO/OIG Accountability Liaison (10OIC GOAL)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Inspection of Select Vet Centers North Atlantic District 1 Zone 2. I have reviewed the recommendations and submitted action plans to address all the findings in the report.
2. Should you require any additional information, please contact Readjustment Counseling Service.

(Original signed by:)

Michael Fisher

[OIG comment: The OIG received the above memorandum from VHA on January 16, 2026, and updated on February 9, 2026.]

Appendix C: RCS North Atlantic District 1 Director Memorandum

Department of Veterans Affairs Memorandum

Date: February 9, 2026

From: District Director, North Atlantic District 1 (RCS1)

Subj: Inspection of Select Vet Centers in North Atlantic District 1 Zone 2

To: Chief Officer, Readjustment Counseling Service (10RCS)

Director, GAO/OIG Accountability Liaison Office (10OIC GOAL)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Inspection of North Atlantic District 1 Zone 2.
2. I have reviewed the draft report and am working with the North Atlantic District 1 leadership team and Vet Center Directors (VCD) to implement a plan of correction and sustainment for all recommendations. District leaders and VCDs took action to begin resolving concerns identified during the inspection and will continue to monitor until there is sufficient evidence to demonstrate compliance with all findings.
3. Please express my thanks to the team for their professionalism and assistance in our continuing efforts to improve the care we provide to our Veterans.

(Original signed by:)

Joanne Boyle

[OIG comment: The OIG received the above memorandum from VHA on January 16, 2026, and updated on February 9, 2026.]

District Director Response

Recommendation 1

District leaders and the Buffalo Vet Center Director collaborate with the supporting VA medical facility to determine reasons for noncompliance with staff participation in the mental health executive council, take action as indicated, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

Vet Center Director (VCD) was not consistently participating in the VA medical facility Mental Health Executive Council (MHEC). District 1 Zone 2 leadership reviewed with the VCD the requirements outlined in VHA Directive 1500(5). The Buffalo Vet Center is now compliant with staff participation in the mental health executive council. District leadership will monitor sustained compliance during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

District leaders and the Buffalo, Nassau, and Syracuse Vet Center Directors determine reasons for noncompliance with completing four hours of external clinical consultation for clinically complex cases per month, ensure a process is implemented to complete consultation requirements, and monitor compliance.

Concur

Nonconcur

Target date for completion: May 2026

Director Comments

The VCDs were not consistently completing and monitoring compliance for the four hours of monthly external consultation at these Vet Centers. District 1 Zone 2 leadership reviewed with VCDs the requirements as outlined by the VHA Directive 1500(5). Nassau and Syracuse Vet Centers are now compliant. The Buffalo VCD is tracking compliance locally, and district

leadership will monitor until there is sufficient evidence to demonstrate compliance. District leadership will verify sustained compliance during the Vet Center Quality Review.

Recommendation 3

District leaders and the Buffalo, Nassau, and Syracuse Vet Center Directors determine reasons for noncompliance with employees completing select training in the required time frame, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: March 2026

Director Comments

In Fiscal Year (FY) 2024, these Vet Centers did not achieve full compliance with mandatory staff training. Non-compliance stemmed from various complications, including issues related to how, when, and who is responsible for assigning training to individuals. District leadership worked to clarify which training courses are assigned at the national, district, and local levels by the VCD and has instructed VCDs to ensure completion of mandatory training. Vet Center staff training is recorded in the Talent Management System (TMS) and tracked locally by VCDs. The staff at the Nassau Vet Center are now compliant. Buffalo Vet Center remains non-compliant with BLS training and have been assigned the training with scheduled completion by January 31, 2026. Syracuse Vet Center remains non-compliant with Suicide prevention training and have been assigned the training with scheduled completion by January 31, 2026. District leadership will verify sustained compliance during the annual Vet Center Quality Review.

Recommendation 4

District leaders and the Buffalo and Nassau Vet Center Directors determine reasons for noncompliance with completion of an outreach plan with all required strategic components, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

During FY24, the outreach plans at these Vet Centers did not include all required strategic components. Reasons for non-compliance included a program transition to a new outreach template during FY24 and a lack of understanding of how certain strategic components were

relevant to their plan. District leadership provided guidance on creating an outreach plan that incorporates all strategic components listed in VHA Directive 1500(5). VCDs and Veterans Outreach Program Specialists are utilizing the current Vet Center Outreach Plan template, and both the Buffalo Vet Center and Nassau Vet Center have updated their outreach plans using their current template, including strategic components. VCDs will track compliance locally on an ongoing basis, and district leadership will verify compliance during the Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 5

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with monthly fire extinguisher inspections, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

The Syracuse Vet Center was not in compliance with monthly fire extinguisher inspections due to a fire extinguisher being located in the OIT closet, which staff were not authorized access to. This fire extinguisher was turned into the local VAMC. A process was developed for the 2 existing fire extinguishers, and they have been compliant for the last six months. VCD will sustain compliance, and District leadership will verify during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 6

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with annual fire extinguisher servicing, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

The Syracuse Vet Center was noncompliant with annual fire extinguisher service. The VCD has worked with VAMC to complete annual inspections and will continue to track on an annual basis, and District leadership will verify during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 7

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with monthly automated external defibrillator inspections, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

The Syracuse Vet Center was not in compliance with monthly Automated External Defibrillator (AED) inspections due to workload and a lack of oversight process. A formal tracking plan was developed and achieved 6 months of compliance and will be monitored for compliance on an ongoing basis. This VCD will sustain compliance, and District leadership will verify during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 8

District leaders and the Syracuse Vet Center Director determine reasons for noncompliance with annual automated external defibrillator servicing by VA medical center biomedical engineering, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

The Syracuse Vet Center was not in compliance with annual AED servicing by VA medical center biomedical engineering. The AED was replaced in October 2025. The Syracuse VCD has contacted Biomed at the VAMC to schedule yearly inspections. The VCD will sustain compliance, and District leadership will verify during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of evidence of new AED or annual AED servicing to support closure.

Recommendation 9

District leaders and the Nassau and Syracuse Vet Center Directors determine reasons for noncompliance with having an emergency and crisis plan that includes required components, ensure completion, and monitor compliance.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

The Syracuse and Nassau Vet Centers were not in compliance with having a current emergency and crisis plan that includes all the required components. District leadership provided VCDs guidance on the required components that needed to be included in the emergency and crisis plan. VCDs updated the plans with the required components. VCDs will continue to sustain compliance, and District leadership will verify sustained compliance during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of emergency and crisis plans that include all required components to support closure.

Recommendation 10

District leaders determine reasons why there are discrepancies in the vet center address on VA and public-facing websites and ensure all websites include correct location information.

Concur

Nonconcur

Target date for completion: Request Closure

Director Comments

There were discrepancies in the Vet Center address on VA and public-facing websites that were likely the result of Vet Center relocations. District leadership has reviewed all VA websites and confirmed accurate addresses for all Zone 2 Vet Centers. VCDs will continue to sustain compliance, and District leadership will verify sustained compliance during the annual Vet Center Quality Review.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation verifying accurate vet center location information to support closure.

Glossary

To go back, press “alt” and “left arrow” keys.

automated external defibrillator. Is “a sophisticated, yet easy-to-use, medical device that can analyze the heart’s rhythm and, if necessary, deliver an electrical shock, or defibrillation, to help the heart to re-establish an effective rhythm.”²⁹

clinical liaison. Mental health professional assigned by the supporting VA medical facility who assist the VCD in coordinating care and suicide prevention activities and making referrals for shared VA medical facility clients.³⁰

high risk suicide flag (HRSF) SharePoint site. Lists names of RCS clients identified by VA medical facilities as high risk. VCDs are required to review the HRSF SharePoint site monthly to identify clients who receive or have received vet center services in the past 12 months to determine the need for client contact, and complete follow-up, as appropriate.

independently licensed mental health external clinical consultant. Is assigned by the supporting VA medical facility to provide vet center counseling staff with a minimum of four hours per month of consultation for clinically complex cases. “In situations where the VA medical facility is unable to provide an external consultant due to local staffing logistics, the Vet Center will be authorized to seek such services from the private sector.”³¹

outreach plan. A written strategic document developed for eligible individuals within that vet center’s service area. The outreach plan identifies specific outreach locations and events that will allow vet center staff to directly provide eligible individuals and families with information about vet center services. Additionally, the outreach plan identifies local service providers, within the VA and non-VA to establish referral networks for vet center clients. Outreach plans are updated annually.³²

²⁹ “What is AED?,” American Red Cross, accessed August 8, 2022, <https://www.redcross.org/take-a-class/aed/using-an-aed/what-is-aed>.

³⁰ VHA Directive 1500(4).

³¹ VHA Directive 1500(4).

³² VHA Directive 1500(4).

OIG Contact and Staff Acknowledgments

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