US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Syracuse Healthcare System in New York

Healthcare Facility Inspection	25-00246-220	August 11, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Syracuse Healthcare System (the facility) from August 12 through 14, 2025. As noted below, the OIG team followed up with the facility in April 2026. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to 42,050 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG had several concerns related to oxygen tank storage, temperature and humidity monitoring, and eyewash stations. The OIG team followed up in April 2026 and confirmed that staff had made improvements and therefore did not make recommendations for these findings.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not have a current policy or service-level workflows that describe staff members' roles in the test result communication process, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[3] Further, the Chief of Staff and the Associate Director for Patient and Nursing Service did not monitor test result communication metrics, also as required by VHA Directive 1088(1). In April 2026,

[1] VHA classifies facilities based on their complexity level. Mid-high-complexity facilities have "medium-high volume, medium risk patients, some complex clinical programs, and medium sized research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack-Operational Statistics Table FY2025 Through September," VHA Support Service Center, last updated March 24, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This website is not publicly accessible.)

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

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

the OIG confirmed that staff had addressed the issues, so did not make any recommendations.

- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.
- **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 recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

The OIG made no recommendations.

VA Comments and OIG Response

The Interim Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes B and C). No further action is required.

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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

ADPNS	Associate Director for Patient and Nursing Service
CBOC	community-based outpatient clinic
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Introduction

The Office of Inspector General'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 programs 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 Syracuse Healthcare System (the facility), located in central New York, includes the Syracuse VA Medical Center and community-based outpatient clinics (CBOCs).[10] The OIG inspected the facility from August 12 through 14, 2025. The Associate Director for Patient and Nursing Service (ADPNS) provided information that showed the facility had 52 medical surgical, 15 intensive care, 16 inpatient mental health, 23 community living center, 15 spinal cord injury, and 3 rehabilitation beds.[11] The facility's budget was approximately $412 million in fiscal year (FY) 2025.[12]

Figure 1. *Facility photo.*
Source: "Syracuse VA Medical Center," VA, updated October 20, 2025, https://www.va.gov/syracuse-health-care.

The executive leaders referred to throughout this report include the Interim Director, Chief of Staff, ADPNS, and Assistant Director.[13] The chief of quality management reported the Associate Director (appointed in 2021), who served as the Interim Director since March 3, 2025, was the longest-tenured leader; the newest was the Chief of Staff, who started in 2024. The Interim Director told the OIG that an Acting Associate Director would be starting the week after the OIG's inspection.

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.[14] 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] "Locations," VA, last updated October 20, 2025, https://www.va.gov/syracuse-health-care/locations.

[11] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/CLC.

[12] "Medical Center Allocation System Reports and Documentation," VA, accessed April 22, 2026, https://vaww.arc.med.va.gov/reports/MCAS_25. (This web page is not publicly accessible.)

[13] VHA directives use the title Associate Director for Patient Care Services, and the facility uses the title Associate Director for Patient and Nursing Service (ADPNS) for the same position. For the purposes of this report, the titles are both used, depending on the context.

[14] 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).[15] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[16]

System Shocks

Executive leaders identified staff departures due to the deferred resignation program, and multiple staff positions that remained unfilled during a federal hiring freeze (in effect from January 20, 2025, to October 15, 2025) as system shocks.[17] Executive leaders told the OIG that staff losses and difficulties filling vacancies had negatively affected facility operations. For example, leaders reported especially high vacancy rates among medical support assistants, who schedule appointments and help manage medical records. Veterans Integrated Service Network (VISN) 2 provided 10 assistants until the facility could hire more.[18] During the OIG inspection in August 2025, leaders explained they were actively recruiting to fill the positions but had received few applications. To reduce the workload on remaining personnel, the Interim Director reported plans to use software that automates phone calls, schedules appointments, and scans medical records into electronic health records.

Additionally, leaders cited frequent turnover in a key leadership position as a system shock. Executive leaders and staff described the instability in the director's position as both disruptive and discouraging. At the time of the OIG inspection, the Interim Director reported that seven individuals had served as either permanent or interim director since 2017.

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

[16] 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.

[17] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 23, 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.

[18] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns; In December 2025, VA announced plans to reorganize and consolidate its VISNs from 18 networks to 5, with the new structure taking effect on June 1, 2026. All 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 within the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/.

Employee Experiences

Many facility respondents to a pre-inspection OIG questionnaire indicated they felt comfortable suggesting actions to improve their work environment but did not view the facility culture as moving in the right direction. Executive leaders reported staff told them about similar concerns and the leaders described some actions they took, which included meeting with groups, discussing concerns, and supporting staff. They regularly visited employees in their work areas to gain a better understanding of their experiences. Leaders explained that they held employees accountable, set clear expectations, and made personnel changes when necessary. Although this led to some employees' departures, leaders viewed these actions as important steps toward improving organizational culture.

The Chief of Staff said leaders historically relied on All Employee Survey scores to assess improvement efforts, but VHA did not administer the survey in FY 2025.[19] Instead, executive leaders developed their own survey for distribution to employees after the OIG inspection that they said would focus on employee perceptions of engagement and leadership. The survey would include text fields for employees to share what they think is going well and what needs to be addressed. Leaders said they also added an employee suggestion box on their internal website to gather concerns and discuss them during weekly all-employee town halls.

To promote psychological safety and morale, the Interim Director said leaders implemented employee awards, recognized systems redesign projects, and introduced initiatives such as stress management through mindfulness (paying attention to the present moment).[20] The ADPNS explained that leaders interview new employees during their first 90 days and then annually to gather feedback, which helps them feel more comfortable discussing issues. The chief of quality management explained that facility employees provided positive feedback in response to executive leaders' efforts.

The Interim Director highlighted that approximately two months before the OIG inspection, executive leaders changed their tiered huddle (daily meetings across multiple levels of staff) format from virtual to in-person to improve communication and encourage service leader dialogue. However, leaders did not conduct a facility-wide rollout of the tiered huddle system, and employees' daily participation varied by service. Executive leaders recognized the varying practices but did not provide a formal strategy for implementation in all services. The OIG also noted the VISN Director expected facilities to use daily tiered huddles at each organizational level. The team conveyed concerns to the Interim Director about the inconsistent communication

[19] The All Employee Survey is an annual, voluntary survey of VA workforce experiences. "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

[20] "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, https://doi.org/10.2147/PRBM.S365311.

practices. However, because the OIG did not identify a VHA requirement for tiered huddles, the concerns did not rise to the level of a recommendation.

Veteran Experiences

The Interim Director said staff track veterans' complaints through a monitoring system, review overdue responses daily, and take corrective actions. A patient advocacy committee reviews complaint trends, identifies root causes, and develops action plans. Patient advocate responses to an OIG questionnaire revealed that delays in phone communication from facility staff were common complaints. Executive leaders acknowledged the issue and attributed it to staff vacancies. To address veterans' concerns, leaders assigned service-level patient advocates to address concerns at the point of service and planned to implement new software that automates phone calls. As shown in figure 2, the facility's VSignals score exceeded the national average, indicating veterans trust the care they receive.

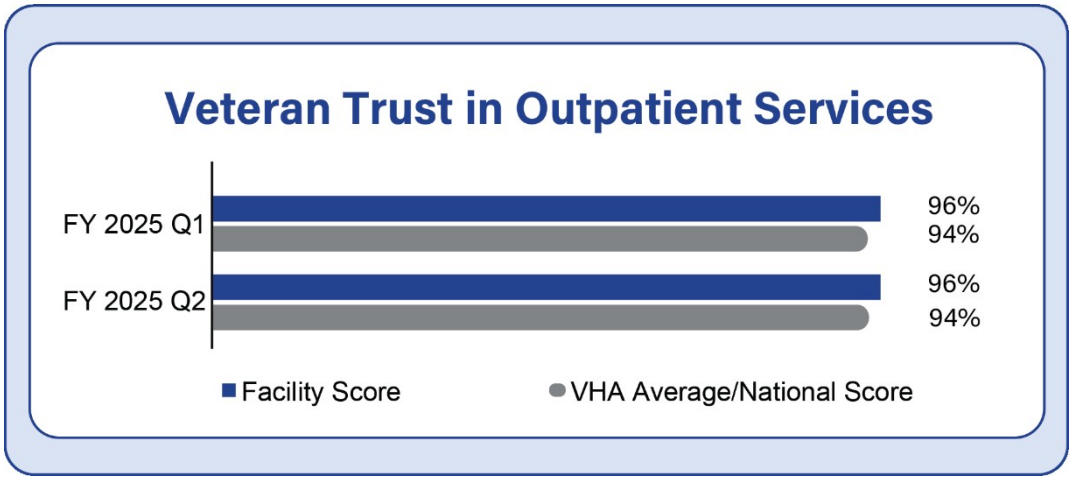

Figure 2. *Veteran trust in outpatient services.*
Source: VSignals data.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[21] 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.[22]

General Inspection

The facility had an eight-story parking garage with sufficient parking, including accessible spaces for those with mobility issues, such as spinal cord injury patients. An enclosed walkway connected the parking garage to the facility, and a facility-operated shuttle transported patients between the parking garage and main entrance. Other transportation options are presented in figure 3. The main lobby was spacious and quiet with a seating area and reception desk staffed with employees available to assist patients with directions.

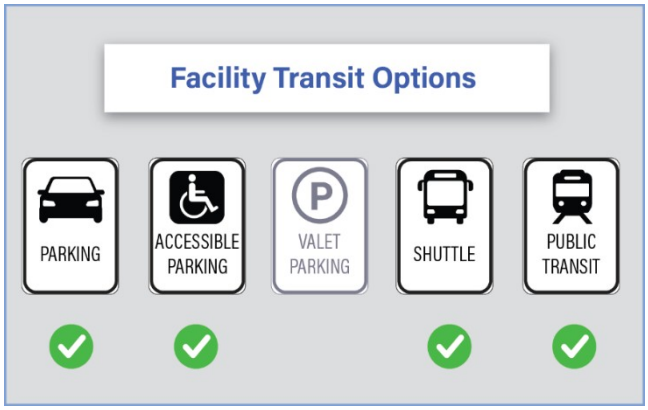

Figure 3. *Transit options for arriving at the facility. Source: OIG analysis of the parking garage floor plan, email correspondence, Syracuse shuttle standard operating procedure, public bus schedule, and questionnaire responses.*

While the OIG team observed wall directories and signs posted throughout the facility for navigation, some signs were incorrect. For example, one listed executive offices on the ground floor, while another listed them on the ninth floor. The inspection team also observed facility staff assisting someone who could not find the way to the emergency room in a hallway leading to that location. Additionally, the OIG team reviewed patient advocate reports and learned that veterans complained about difficulties navigating from the parking garage to the main entrance

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

[22] 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.

using posted signs, a challenge that the inspection team experienced as well. The OIG shared these observations with facility leaders during the inspection who were receptive to the feedback.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG analysis of questionnaire responses and observations.

The facility offered assistive listening devices such as personal sound amplifiers to hearing-impaired veterans. The OIG team also observed braille on signs and large-print directories, which may help veterans with visual impairments navigate the facility. Additionally, facility documents showed the facility had a Low Vision Clinic, where employees helped visually impaired veterans obtain assistive tools, such as handheld magnifiers to enlarge printed materials and devices that read print aloud. The OIG did not observe closed captioning displayed on facility televisions.

As to cleanliness, OIG inspectors reviewed an April 2025 VISN Annual Facility Evaluation that identified dust on vertical and horizontal areas in the Prosthetics Department.[23] During the OIG's August 2025 inspection, the team found the facility to be generally clean, but the inspection team noted dust under beds and on an overhead surgical lamp in the Emergency Department. There were also dirty floors and a damaged cabinet with exposed particle board. The chief of facility management services reported a plan to renovate the Emergency Department in 2027. The OIG did not make a recommendation because of the facility's general cleanliness and the planned renovation.

Also in the Emergency Department, the OIG observed patient identification information (names and Social Security numbers) displayed on an electrocardiogram machine (which measures electrical signals in the heart) that did not secure patient information.[24] The electrocardiogram machine stored near patient rooms was accessible to anyone in the area. The *Health Insurance Portability and Accountability Act* requires healthcare organizations to protect patients' health information, including demographic data such as name, birth date, and Social Security number.[25]

[23] VA New York/New Jersey VA Health Care Network, *Annual Facility Evaluation for Syracuse VAMC [VA Medical Center]*, April 22, 2025.

[24] "Electrocardiogram," John Hopkins Medicine, accessed February 5, 2026, https://www.hopkinsmedicine.org/electrocardiogram; "Vital Signs (Body Temperature, Pulse Rate, Respirations Rate, Blood Pressure)," John Hopkins Medicine, accessed February 5, 2026, https://www.hopkinsmedicine.org/vitalsigns.

[25] Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

The chief of healthcare technology management stated the electrocardiogram machine included an option to erase information once facility staff sent it to the patient's electronic health record and was unsure why the data were not clearing. The OIG did not make a recommendation because the chief reported a plan to evaluate the machines and update settings if needed to store and protect patient information.

Additionally, OIG inspectors observed a large liquid nitrogen storage tank stored in a small room that formerly served as the shower area of a patient exam room. Liquid nitrogen converts to a nonflammable, odorless gas at room temperature and, when released in confined spaces, may displace available oxygen and cause asphyxiation (lack of oxygen to the body). The chief of facility management service reported that the room where the tank was located did not meet standards in the National Fire Protection Association's *NFPA 99 Health Care Facilities Code* for liquid nitrogen storage. Because facility staff had already located a new area to store the tank, the OIG did not make a recommendation.[26]

The OIG also reviewed an October 2024 Joint Commission report that found partial and full oxygen tanks stored together in an area for full tanks only.[27] During the OIG's August 2025 inspection, there were full, partial, and empty oxygen tanks stored beside each other at a public entrance. The National Fire Protection Association's *NFPA 99 Health Care Facilities Code* states that "if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders," which may prevent confusion and misuse.[28] When asked by the inspection team, staff near the storage area did not know who was responsible for the oxygen tanks. Before the OIG departed from the facility, the chief supply chain officer said facility staff had removed all the oxygen tanks from the entrance.

Further, the OIG noted that staff did not complete daily logs to track temperature and humidity in supply rooms, as required by VHA Directive 1761, *Supply Chain Management Operations*.[29] For example, inspectors observed a temperature and humidity log in the Emergency Department that did not have daily entries. Maintaining proper temperature and humidity in supply rooms is critical to ensuring the integrity, safety, and effectiveness of stored medical supplies and equipment. The OIG team also found staff did not consistently monitor unrefrigerated medications kept in the medication rooms, as required by VHA Directive 1108.07(2), *General*

[26] The National Fire Protection Association, *NFPA 99 Health Care Facilities Code*, 2024 Edition, 11.3.5.2, September 14, 2023.

[27] Joint Commission Health Care Organization, *VA Healthcare Network Upstate New York at Syracuse*, *Accreditation Activity—60-day Evidence of Standards Compliance*, October 28, 2024.

[28] The National Fire Protection Association, *NFPA 99 Health Care Facilities Code*, 2024 Edition, 11.6.5.2, September 14, 2023.

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

Pharmacy Service Requirements.[30] The chief of facility management service told the OIG that staff did not ensure medication storage areas maintained temperature and humidity within a certain range. The team followed up in April 2026 and reviewed evidence that showed facility staff had monitored supply and medication storage rooms and purchased a remote monitoring system in January 2026. Based on these updates, the OIG did not make a recommendation.

During the August 2025 inspection, the OIG identified various issues with the facility's eyewash stations. This reflected an ongoing issue with eyewash areas. For example, the 2024 Joint Commission report found stations with eyewash caps not attached to spouts, and an April 2025 VISN Annual Facility Evaluation report found training deficiencies for the use and maintenance of eyewash stations.[31] These included expired eyewash fluid in a utility room, which could make the fluid ineffective when flushing eyes of harmful material. In the intensive care unit, an eyewash station was blocked by equipment, which restricted access. According to the Code of Federal Regulations, title 29, section 1910.151(c), facilities for flushing eyes must be nearby so anyone exposed to harmful chemicals can immediately rinse them.[32] Additionally, the eyewash station was located above a cord plugged into an electrical outlet, which posed an electrocution risk for staff. In April 2026, facility staff provided evidence that leaders completed a risk assessment to determine where eyewash stations were needed and planned to continue to monitor stations during environment of care rounds. Based on these updates, the OIG did not make a recommendation.

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

Communication of Urgent but Noncritical Test Results

The facility's test result communications policy expired in 2021.[33] VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* requires facility staff to create a policy

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

[31] Joint Commission Health Care Organization, *VA Healthcare Network Upstate New York at Syracuse, Accreditation Activity—60-day Evidence of Standards Compliance*; VA New York/New Jersey VA Health Care Network, *Annual Facility Evaluation for Syracuse VAMC*.

[32] 29 C.F.R. § 1910.151(c) (2025).

[33] VA Healthcare Network Upstate New York, Syracuse, Medical Center Professional Memorandum (MCPM) 11-004, *Communicating Test Results to Providers and Patients*, December 2019.

that defines how staff communicate test results.[34] Policies that remain outdated for many years may affect staff awareness of requirements and the delivery of quality clinical care and patient safety. The document control coordinator stated that each service must update their policies in accordance with VHA directives, but the facility lacked a formal process to ensure updates occur.

The OIG found executive leaders did not meet VHA requirements:

- On July 11, 2023, VHA issued Directive 1088, which required that facilities create a local policy and service-level workflows within 6 to 12 months.[35]
- On August 8, 2024, the document control coordinator emailed a policy update request to several leaders, but not the Chief of Staff, who was identified as the facility policy owner (staff responsible for the policy).
- Before this inspection, the OIG published several reports that identified similar policy gaps at other facilities that were made available to all VA medical centers to proactively address deficiencies identified in OIG inspections, regardless of location.[36]

The Chief of Staff reported that facility staff began to revise the outdated policy a month before the OIG's August 2025 inspection and recognized the need for a better system to track and update policies. The OIG team followed up in April 2026 and found that facility staff updated the policy in December 2025. Based on this action, the OIG did not make a recommendation.

The facility had test result communication workflows for the Pathology and Laboratory Medicine and Imaging Services, but not other services. VHA Directive 1088(1) requires the Chief of Staff and ADPNS to ensure each service develops (or adapts from other services) written workflows that "identify all providers and staff who can communicate test results to patients."[37] Service-level workflows are important because they provide written instructions "that describe the role of various team members in the test results communication process."[38] In an interview, the associate chief of staff for ambulatory care acknowledged the lack of a service workflow but described the current process, and said a draft written workflow was in progress. The Chief of Staff reported contacting other facilities for examples to use as a starting point. In

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

[35] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[36] VA OIG, *Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia*, Report No. 24-00592-60, March 6, 2025; VA OIG, *Healthcare Facility Inspection of the VA Hampton Healthcare System in Virginia*, Report No. 24-00603-86, March 26, 2025.

[37] VHA Directive 1088(1).

[38] VHA Directive 1088(1).

April 2026, facility staff provided evidence of service-level workflows. Because of this remedial step, the OIG did not make a recommendation.

The OIG team also reviewed the facility's test result communications metric—the percentage of outpatient tests with abnormal results that were communicated to patients within the seven days required by VHA Directive 1088(1)—and found that scores for the first quarter of FY 2025 were below 90 percent. The ADPNS told the OIG that facility performance should be closer to 100 percent, but neither the ADPNS nor the Chief of Staff could explain why the scores remained below expectations.

Further, the Chief of Staff and the ADPNS reported in interviews they did not routinely attend the monthly meetings to evaluate results from patients' electronic health record reviews, including test results that staff did not communicate within seven days. According to VHA Directive 1088(1), the Chief of Staff and the Associate Director for Patient Care Services must review the data and take corrective action as necessary. The OIG team conducted a follow-up call with facility staff in April 2026 and reviewed evidence showing they reported test result communications data to leaders. As a result, the OIG did not make a recommendation.

To improve performance in FY 2025, the associate chief of staff for ambulatory care incorporated test result communications metrics into team meetings and set expectations in the orientation for new and contracted providers to meet them. Additionally, the associate chief shared that providers receive quarterly updates on their individual metric scores, which supervisors also review during performance evaluations.

The chief of imaging said the service conducts monthly peer reviews to assess provider compliance with the established test result communications workflow. If a provider does not meet expectations, the chief provides any needed education and initiates a focused performance review (in which the service chief assesses their clinical privileges).[39]

The chief of pathology and laboratory medicine stated the quality assurance coordinator audits each section of the laboratory and reports the findings monthly during staff meetings and quarterly to the facility's quality assurance team. The chief also noted that a supervisor reviews all critical results reported in the previous 24 hours to confirm laboratory staff appropriately followed up with providers.

Action Plans and Process Improvements

The facility's last OIG healthcare inspection occurred in March 2023, and all recommendations were closed as sufficiently implemented.[40] During an interview, the inspection team asked

[39] VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[40] VA OIG, *Comprehensive Healthcare Inspection of the Syracuse VA Medical Center in New York*, Report No. 23-00016-132, April 9, 2024.

quality management staff about executing and sustaining action plans based on prior recommendations. The chief of quality management explained that in response to a 2024 OIG report on another VA healthcare system, VISN leaders directed facilities to conduct a clinical look-back (a process to identify patients who may have been exposed to risk) on patients who experienced significant delays in community care consults.[41] In response, quality management staff completed a retrospective review of patients' electronic health records to identify care delays and take appropriate action. This review led them to complete seven institutional disclosures of adverse patient care events.[42]

Additionally, the OIG reviewed facility documents and found two missed opportunities for patient safety staff to fully evaluate some adverse events for system-wide improvements and prevent reoccurrence. The team referred these events to OIG's hotline management personnel for further review.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[43] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The OIG reviewed documents that confirmed the facility provided primary care services at the Syracuse medical center clinic and seven CBOCs. The facility operated two CBOCs and contracted with companies to manage the other five.[44] The OIG noted the VHA-managed

[41] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393. VA OIG, *Leaders Failed to Address Community Care Consult Delays Despite Staff's Advocacy Efforts at VA Western New York Healthcare System in Buffalo*, Report No. 23-03679-262, September 27, 2024; VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[42] An institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care." VHA Directive 1004.08.

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

[44] The facility-operated clinics were in Binghamton, Rome, and Syracuse. The other clinics were in Auburn, Potsdam, and Watertown, contracted by one company, and Ithaca-Thompkins County and Oswego, operated by a different contract company.

CBOCs supported 26 primary care teams, while the contracted CBOCs supported 14 teams, for a total of 40 teams.

Primary care leaders reported in an interview that both the VHA-managed CBOCs and contracted CBOCs had vacancies for providers, registered nurses, licensed practical nurses, and medical support assistants at the time of the inspection in August 2025. The associate chief nurse for primary care said recruitment efforts were in progress and provided documents to show contingency plan coverage for all vacancies. Additionally, the Chief of Staff noted that ongoing facility-wide staffing vacancies increased workloads. For example, primary care staff explained that approximately six months prior to the August 2025 OIG inspection, facility leaders reduced outpatient blood draw hours (the times patients can go to the laboratory to have their blood collected) and shifted blood draws to primary care clinics after 3:00 p.m. to accommodate the vacancies.

Community Care Staffing and Access to Care

During OIG interviews, the community care chief explained that provider vacancies at the facility contributed to a 37 percent rise in community care referrals during FY 2025. Specialty care services such as—orthopedics (treatment of bone conditions), complementary and integrative health (nonconventional medical care), dermatology (skin diseases), cardiology (heart specialty), and gastroenterology (care of stomach and intestines)—generated the highest number of referrals.[45] The chief also reported an average of 27 days for staff to schedule community appointments in FY 2025, which did not meet the 7-day scheduling target set by VHA's *Consult Timeliness Standard Operating Procedure.*[46] The chief attributed the delay to the following factors:

- Clinic staff took an average of 9 days to process and forward referrals to the community care program, accounting for a significant part of the delay.
- Community care staff misinterpreted VHA's *Consult Timeliness Standard Operating Procedure*, believing it allowed up to 14 days for veterans to respond to initial contact attempts, limiting their ability to meet the 7-day benchmark.[47]

[45] *Merriam-Webster*, "Orthopedics," accessed February 9, 2026, https://www.merriam-webster.com/orthopedics; "Complementary and Integrative Health," VA, Office of Research and Development, updated January 15, 2021, https://www.research.va.gov/topics; *Merriam-Webster*, "Dermatology," accessed August 25, 2025, https://www.merriam-webster.com/dermatology; *Merriam-Webster*, "Cardiology," accessed August 25, 2025, https://www.merriam-webster.com/cardiology; *Merriam-Webster*, "Gastroenterology," accessed August 25, 2025, https://www.merriam-webster.com/gastroenterology.

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

[47] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)."

The team did not make a recommendation because the OIG's review of VHA data through May 2026 showed the facility had improved its average time to schedule community appointments to 21 days, demonstrating progress in reducing delays.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[48]

During this inspection, VHA used three performance measures to determine the success of each medical facility's program. The first, HCHV5, measured the percentage of veterans who received an HCHV program intake assessment.[49] However, this fiscal year (FY 2026), VHA no longer uses intake percentage as a performance measure. The second measure used during the inspection, HCHV1, measured 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

Through street outreach, HCHV staff identified a homeless veteran and visited them multiple times, bringing food, personal hygiene items, and clothing. Although the veteran declined the staff's offer of transitional housing and was not interested in a housing voucher, they eventually agreed to permanent housing after continued engagement. Staff helped the veteran complete the housing application and coordinated temporary financial assistance with community providers, enabling the veteran to move into a fully furnished housing unit.

Figure 5. *Success story of an unsheltered veteran achieving permanent housing.*
Source: OIG questionnaire responses.

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

[49] VHA's goal is for facility program staff to perform intake assessments for all identified veterans by the end of each fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024.

veterans with mental health or substance use conditions).[50] Finally, HCHV2 measured the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[51]

Performance and Improvement Highlights

- The program did not meet any of the three metrics in quarter one of FY 2025 but met them in quarter two. The mental health special programs manager reported challenges to meeting the metrics included program staff vacancies and a contracted emergency residential services program that served veterans with acute mental health and substance use issues, which often prevented them from successfully finding them permanent housing. The director of community case management services reported that during the fourth quarter of FY 2025, facility staff and community case managers participated in an event to assist veterans in Oswego and Cayuga Counties. They made 195 stops, distributed essential supplies, and shared community resources and program information.

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."[52] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[53]

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

[50] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*. 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.

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

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

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

veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[54]

Performance and Improvement Highlights

- A facility program staff member attributed not meeting the voucher use (HMLS3) target for the first and second quarters of FY 2025 to limited affordable housing. The program did meet the employment (VASH3) target for the first and second quarters of FY 2025.
- Program staff highlighted support community partners who covered application fees, security deposits, and portions of first-month rent for veterans.[55]
- Staff added that one community partner offered incentive payments to landlords who rented to veterans, and another helped a veteran pay a pet deposit. Staff also partnered with an apartment community that houses adults aged 62 and older that prioritizes veterans.

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.[56] 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).[57]

Performance and Improvement Highlights

- The program met the enrollment (VJP1) target for the first and second quarters of FY 2025.
- Facility documents showed that program outreach specialists supported veterans in treatment courts, prisons, and jails, and received referrals from justice partners and

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

[55] "Who Are the Elks?," Elks USA, accessed August 25, 2025, https://www.elks.org/who; "About Us," Tunnel to Towers Foundation, accessed August 25, 2025, https://t2t.org.

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

[57] 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.*

other staff from the facility.[58] The New York State Department of Corrections also referred veterans based on release lists of individuals leaving incarceration.

- The program outreach specialists reported providing crisis intervention training to law enforcement agencies to support earlier veteran interventions through treatment and program referrals.

Conclusion

To assist leaders in evaluating the quality of care at the Syracuse facility, the OIG conducted an inspection across five domains. No recommendations are included in this report. 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.

[58] "A treatment court is a long-term judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data and relevant prior OIG and accreditation survey reports. The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from August 12 through August 14, 2025. 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.

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.[59] 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*.[60]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[61] 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. 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 OIG inspection team followed up with facility staff in April 2026 to review their responses to the team's concerns.

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

[60] 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.

[61] 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.

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 issues.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[62] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 17, 2026

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: Healthcare Facility Inspection of the VA Syracuse Healthcare System in New York

To: Director, Office of Healthcare Inspections (54HF03)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the VA OIG DRAFT REPORT - Healthcare Facility Inspection of the VA Syracuse Healthcare System in New York. I concur with the report finding which resulted in no recommendations. We are grateful to the employees and facility leadership that have worked diligently to provide excellent care for our Veterans.

We thank the OIG for a thorough review and their ongoing commitment to improve the quality of health care for the Nation's Veterans.

(Original signed by:)

Bruce Tucker, LCSW
Interim Network Director, VISN 2

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 30, 2026

From: Director, VA Syracuse Healthcare System (528A7)

Subj: Healthcare Facility Inspection of the VA Syracuse Healthcare System in New York

To: Director, New York/New Jersey VA Health Care Network (10N2)

Thank you for the opportunity to review the draft report from the Office of Inspector General's Healthcare Facility Inspection of the Syracuse VA Healthcare System. I have completed my review and concur with the finding of no recommendations. I appreciate the continued partnership with the OIG to ensure that the Veterans we proudly serve receive the highest quality of care.

(Original signed by:)

Mr. Michael DelDuca, MBA-HCM
Medical Center Director

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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.