US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

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

Healthcare Facility Inspection	25-00256-276	September 25, 2026

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

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Albany Healthcare System (the facility) from September 23 through 25, 2025. In June 2026, the facility provided an update. The facility is rated as *mid-high complexity* and in fiscal year 2025, provided direct care to about 30,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG noted that the facility's approach to addressing changes included effective leadership practices and organizational responses. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team identified protected patient health information that was not properly secured, as required by VHA Directive 1605.01, *Privacy and Release of Information*, and staff did not maintain a clean environment, in accordance with VHA Directive 1608(1), *Comprehensive Environment of Care Program*.[3] The OIG made three associated recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. OIG inspectors found the Chief of Staff and the

[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." VA, "Facility Trip Pack – (VISN 2) Samuel S. Stratton Department of Veterans Affairs Medical Center," last updated April 14, 2025; "VHA Station Listing," VHA Support Service Center, accessed September 30, 2025, https://reports.vssc.med.va.gov//ReportViewer/VAST. (This web page is not publicly accessible).

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

[3] Protected health information includes individually identifiable health information related to the provision of health care. Individually identifiable health information refers to information that can be used to distinguish or trace an individual's identity, such as demographics, that relates to health and well-being or payment for health care. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104–191, 110 Stat. 1936 (1996); 42 U.S.C. § 1320(d), 45 C.F.R. pts. 160 and 164 (2025). VHA Directive 1605.01, *Privacy and Release of Information*, July 24, 2023; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

Associate Director for Patient Care Services did not regularly review performance data to ensure providers communicated test results that require action to patients within seven days, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[4] The OIG made one recommendation.

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

What the OIG Recommended

1. The Director takes appropriate actions to have staff safeguard patients' protected health information, as required by Veterans Health Administration Directive 1605.01, *Privacy and Release of Information*.
2. The Director takes appropriate actions to have staff maintain a clean environment, consistent with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
3. The Director takes appropriate actions to have staff maintain clean food and medication refrigerators, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
4. The Chief of Staff and Associate Director for Patient Care Services monitor performance data for test result communication, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

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

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

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the findings and recommendations and provided acceptable action plans (see the responses in the report body and appendixes B and C for the full text of the directors' comments).[6] Based on information provided, the OIG considers recommendation 4 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

DAVID KRULAK, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

[6] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

Abbreviations

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

Contents

Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[7] 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.[8]

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.[9]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[10]

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.[11]

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[7] "About VHA," VA, last updated June 2, 2026, https://www.va.gov/aboutvha.

[8] 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.

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

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

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

The VA Albany Healthcare System (the facility) began serving patients in 1951. The facility's budget was approximately $294.6 million in fiscal year (FY) 2025, and it had 55 hospital, 50 community living center, and 12 domiciliary beds.[12]

Figure 1. *Facility photo.*
Source: "VA Albany Health Care," VA, accessed February 9, 2026, https://www.va.gov/albany-health-care.

The OIG team inspected the facility from September 23 through 25, 2025. The facility provided an update in June 2026. The executive leaders referred to throughout this report include the Medical Center Director (Director), Associate Medical Center Director (Associate Director), Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Assistant Medical Center Director. The quality manager reported the newest members of the team were the Chief of Staff and ADPCS, both assigned in June 2025.

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.[13] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[14] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[15]

[12] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv.

[13] 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.

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

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

System Shocks

Although executive leaders did not identify any system shocks during interviews, they said they activated the facility's emergency response incident command team in early 2025 to review and manage presidential memorandums and executive orders.[16] The Chief of Staff stated that initial uncertainty about VHA's exemptions to the hiring freeze and the inability to fill some positions negatively affected employee morale. The Director also acknowledged that instructions to send a weekly email describing five job-related accomplishments to the Department of Government Efficiency increased employee stress.[17] Additionally, the Chief of Staff said the termination of gender-affirming care caused moral distress for some employees.

Executive leaders reported the incident command team coordinated activities in response to mandatory in-person work, an anticipated reduction in force (layoffs), a hiring freeze (in effect from January 20, 2025, to October 15, 2025), and changes to the provision of transgender care.[18] According to the Director, the incident command team streamlined decision-making, clarified employee roles and responsibilities, coordinated efforts across services, and reallocated resources to address the changes. Executive leaders said the team reviewed the changes, then agreed on a single, clear message to communicate to employees.

Executive leaders also told the OIG team the facility did not experience a reduction in force; few employees were affected by the in-person work mandate; and they continued to hire for positions on the hiring freeze exemption list.[19] Executive leaders emphasized transparent communication to reduce employee stress and said they were highly attentive to their concerns during the changes. For example, leaders held town halls and helped some employees apply for exemptions to the return to in-person work mandate. The OIG found the facility's approach to addressing changes included effective leadership practices and organizational responses.

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[16] During an event that requires an immediate response, VHA uses the incident command system for effective and efficient management. VHA Directive 0320.02, *Veterans Health Administration Health Care Continuity Program*, January 22, 2020.

[17] Charles Ezell, Acting Director, Office of Personnel Management, "Guidance on Government-wide Email *What Did You Do Last Week?*," memorandum to Heads and Acting Heads of Department and Agencies, February 24, 2025.

[18] Return to In-Person Work, 90 Fed. Reg. 8251 (Jan. 28, 2025); Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025); Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025; Defending Women from Gender Ideology Extremism and Restoring Biological Truth to the Federal Government, 90 Fed. Reg. 8615 (Jan. 30, 2025).

[19] The executive order prohibits leaders from hiring employees, filling any position, or creating new positions except when "the Director of the Office of Personnel Management" grants an exemption. Hiring Freeze, 90 Fed. Reg. 8247.

Employee Experiences

Most OIG questionnaire respondents indicated executive leader communication was clear, useful, and frequent. Executive leaders explained they communicate with employees through a variety of means, including weekly rounds (visits to work areas), monthly newsletters, quarterly town halls, and tiered huddles (short meetings between leaders and employees to share problems and identify solutions).[20] The majority of respondents also indicated they feel comfortable reporting safety issues and suggesting actions to improve their work environment (see figure 2).

Executive leaders reported that employees often shared performance improvement ideas during rounds. For example, a respiratory therapist voiced a concern that employees were not connecting the suction system (used to clear secretions from patients' airways) to wall vacuums on patients' admission. As a result, leaders implemented a checklist that included suction system setup to ensure timely airway management when patients are in distress.

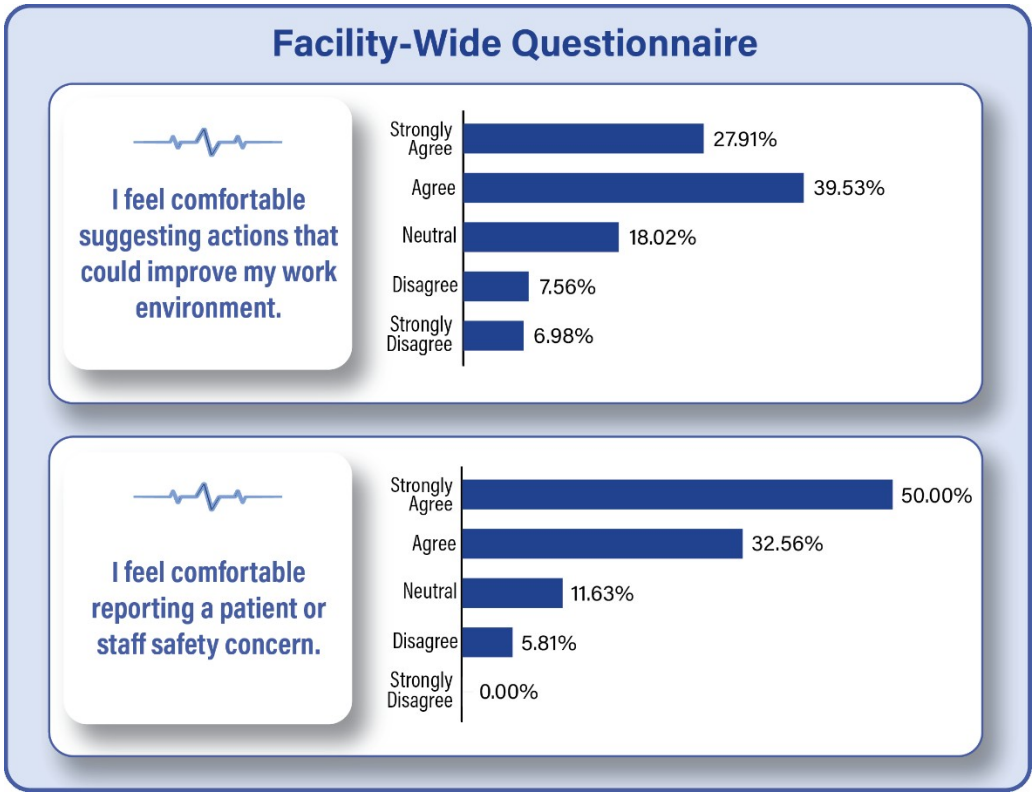

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

[20] "VHA National Center for Patient Safety, Patient Safety Huddle Board," VA, last updated April 3, 2018, https://www.patientsafety.va.gov/Patient_Safety_Huddle_Board.

Although most OIG questionnaire respondents reported they feel connected to the mission and did not think about leaving the facility, others cited stress and burnout as the primary reasons they would consider leaving. Executive leaders said they conducted meetings with facility supervisors to ensure workload levels and productivity standards were appropriate.

While executive leaders said they made efforts to address workload balances, they did not perceive employees as stressed or burned out. According to the Chief of Staff, many employees were anxious about future staffing levels given current hiring limitations and vacancies in various services, but they remained dedicated to caring for veterans. To support employees, executive leaders stated they remained highly visible and approachable and expressed concern for employee well-being. They reported employees frequently recommended the facility to job seekers, which shows they view the facility as an employer of choice.

Veteran Experiences

Patient advocate responses to the OIG questionnaire showed the most frequent veteran concerns involved unanswered phone calls to facility employees. Executive leaders reported that a recent telephone system upgrade helped resolve some issues. However, it was a challenge to ensure there were sufficient employees to answer calls due to staffing losses, and they worked to confirm appropriate coverage within clinics.

Questionnaire respondents also indicated executive leaders were responsive to veterans' concerns. One advocate shared an example of the Chief of Staff demonstrating compassion and leadership by helping a deceased veteran's family fix a billing issue.

According to the Director, staff completed training that enabled them to resolve concerns within services instead of referring veterans to the patient advocates. The ADPCS also said nursing leaders round on inpatient units and help identify and resolve veteran concerns. VSignals outpatient trust scores steadily increased from 94 percent in FY 2024 to 96 percent in the third quarter of FY 2025, remaining slightly above VHA averages.

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.

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

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 OIG team noted the entrance appeared clean, well-lit, and welcoming. The lobby provided ample seating and a café with space for veterans to socialize. Staff and volunteers at the front desk offered directions, answered questions, and escorted veterans to their destinations. When asked, staff informed the OIG that sign language interpretation services were not available.

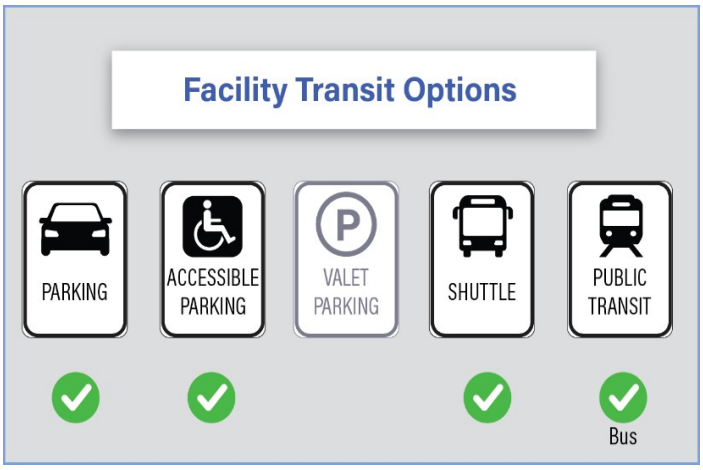

Figure 3. *Transit options for arriving at the facility. Source: OIG observations, facility liaison questionnaire responses, interview with the accreditation quality specialist, and a facility map.*

Lobby signs identified facility locations. However, the OIG found multiple locations where the emergency exit signs did not lead to the closest exit, or they led to a secured construction zone; in some cases, directional signs ended before reaching the closest exit. The Code of Federal Regulations (title 29, section 1910.37) mandates that facilities have clear, visible, and accurate exit routes, and The Joint Commission's standard LS [Life Safety] 01.02.01 requires medical facilities to protect occupants during construction.[23] Incorrect or incomplete directional signs can delay evacuation during emergencies, increase confusion, and potentially lead veterans or staff into hazardous or inaccessible areas.

The chief of occupational safety and health was unaware of the issues with emergency exit signs. During an interview, the chief said that staff use safety procedures to reroute emergency exit pathways, assess sign accuracy during weekly construction safety rounds, and immediately correct identified problems. In June 2026, the facility quality manager provided an update and reported that staff completed a project to improve signs in stairwells, elevator lobbies, and the main building.

[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.

[23] 29 C.F.R. § 1910.37 (2025); The Joint Commission, *Standards Manual*, E-dition, LS.01.02.01, July 1, 2025.

The team also observed protected patient health information not properly secured at a provider's desk located in the emergency department nursing station, and on carts stored in the dialysis unit's hallway.[24] VHA Directive 1605.01, *Privacy and Release of Information*, requires staff to protect patients' health information against unauthorized access, use, or disclosure.[25] When staff leave such information in unsecured areas, it increases the likelihood of a privacy breach or identity theft.

Recommendation 1

The Director takes appropriate actions to have staff safeguard patients' protected health information, as required by Veterans Health Administration Directive 1605.01, *Privacy and Release of Information*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

The Privacy Officer will perform unannounced audits each month across the ED, dialysis, and two rotating units, using the privacy national audit tool. After each audit cycle, results will be submitted to the QSV Committee monthly. This regular reporting will continue until audit scores reach above 90% for six consecutive months. Once compliance is sustained, ongoing monitoring frequency will be determined by the QSV Committee.

The OIG team learned that dialysis unit staff prepared their own disinfectant wipes because the hemodialysis equipment required a specific concentration of bleach for cleaning. However, the OIG found that the unit staff made disinfecting wipes in an area without an eyewash station. This was also a finding in the Veterans Integrated Service Network (VISN) Annual Workplace

[24] Protected health information includes individually identifiable health information related to the provision of health care. Individually identifiable health information refers to information that can be used to distinguish or trace an individual's identity, such as demographics, that relates to health and well-being or payment for health care. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104–191, 110 Stat. 1936; 42 U.S.C. § 1320(d), 45 C.F.R. pts. 160 and 164 (2026).

[25] VHA Directive 1605.01, *Privacy and Release of Information*, July 24, 2023.

Evaluation report from January 2025.[26] The absence of an eyewash station in the area presents a safety risk to staff because bleach can cause serious eye and skin injuries. In June 2026, the facility quality manager reported that staff now prepare wipes in a room with an eyewash station, and infection prevention nurses check to ensure that staff prepare them in the correct location. The facility quality manager explained that staff researched options for pre-made wipes, but no compatible product was available.

The team also identified multiple areas in need of housekeeping services, especially in the emergency department. Inspectors noted dusty and soiled surfaces and floors, as well as debris and dead insects on the floor in a soiled utility closet and in a bin located inside a locked dispensing unit in the medication room. Staff corrected many of these issues during the week of the inspection in September 2025, but the OIG team remains concerned that staff face significant challenges in maintaining a clean environment, as required by VHA Directive 1608(1), *Comprehensive Environment of Care Program*.

The environmental services chief stated that VHA's strategic hiring initiative led to a reduction in staffing, and the accreditation manager provided documents showing a loss of nine full time and one part time environmental services staff between January 2024 and July 2025.[27] The chief explained that vacancies resulted from promotions, retirements, and resignations (including five the week of the OIG's inspection in September 2025) due to the heavy workload and competitive pay in similar local positions. Additionally, the hiring process can take three to six months, which causes some applicants to lose interest.

The environmental services chief stated staff worked outside their roles to cover vacancies; for example, the chief helped with housekeeping aide supervisor duties while supervisors worked as housekeeping aides. Supervisors had also trained staff and evaluated staff competencies since the training instructor retired in February 2025. In December 2025, the facility liaison stated the service leader was selecting candidates for four vacant supervisor positions; anticipated offering a temporary promotion to fill the training instructor position; and had approval to hire for 8 of 16

[26] VISN 2, *Annual Workplace Evaluation: Albany Straton Veterans Affairs Medical Center*, January 2025; Veterans Integrated Service Networks are "regional care systems working together to better meet local healthcare needs and provide greater access to care." "Veterans Integrated Service Networks," VA, last updated July 24, 2026, https://department.va.gov/visns. In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the VISNs from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's inspection. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise.

[27] VHA's FY 2024 strategic hiring initiative directed executive leaders to prioritize hiring essential positions without increasing staffing levels. Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23), Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024.

housekeeping aide vacancies, with interviews underway. An update provided by the facility quality manager in June 2026 indicated that the environmental services department had

- hired four new supervisors in January;
- temporarily promoted a management assistant into the training instructor position, and
- hired three new housekeeping aides and made tentative offers to an additional five.

Further, the housekeeping aide position posting remains open so leaders can continue to recruit for anticipated vacancies.

Recommendation 2

The Director takes appropriate actions to have staff maintain a clean environment, consistent with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

To strengthen environmental cleanliness oversight in 24/7 operational areas, Environmental Management Service (EMS) Supervisors will conduct high touch surface audits during routine shift rounds. Audit results will be documented in the designated EMS software system. Findings and compliance rates will be reported monthly to the Quality, Safety, and Value (QSV) Committee. This corrective action will remain active until audit performance reaches and sustains a minimum of 90% compliance for six consecutive months. Once compliance is sustained, ongoing monitoring frequency will be determined by the QSV Committee.

The OIG team also found multiple food and medication refrigerators with dirty surfaces and gaskets on patient care units. Staff who toured the facility with the inspectors stated pharmacy staff were responsible for cleaning medication refrigerators.

Staff then provided the OIG team with facility procedures and policies on food and medication refrigerators. The nursing procedure for medication refrigerators states "nursing staff will ensure medication refrigerators are clean," but the nurse managers were not able to provide the OIG inspector with a cleaning schedule.[28] The policy for food refrigerators instructs staff to discard expired food and wipe up spills daily and ensure food is stored according to food sanitation and

[28] Albany Stratton VA Medical Center, "Medication Rooms" (nursing procedure), August 19, 2021.

safety guidelines monthly.[29] It is important for staff to maintain a clean environment to reduce the risk of healthcare-associated infections to patients.[30]

Recommendation 3

The Director takes appropriate actions to have staff maintain clean food and medication refrigerators, in accordance with Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

__X__ Concur

_____ Nonconcur

Target date for completion: March 31, 2027

Director Comments

Medical Center Director will direct the In-patient Associate Chief Nurse and the Chief of Nutrition and Food Services to implement a process for monitoring refrigerators in their services. A new standards operating procedure (SOP) is being developed. After SOP is approved, cleaning log compliance will then be monitored monthly and reported to the Quality, Safety, and Value (QSV) Committee until six months of compliance is achieved. Once compliance is sustained, ongoing monitoring frequency will be determined by the QSV Committee.

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, Noncritical Test Results

The OIG team reviewed documents and interviewed staff and determined there was an established process to communicate test results to providers and patients, which aligned with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[31] This process included established time frames to communicate test results; steps for providers to designate

[29] Albany Stratton VA Medical Center, "Patient Nourishment Refrigerators" (standard operating procedure), February 2, 2022.

[30] VHA Directive 1608(1).

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

surrogates in their absence; a list of staff to communicate results; after-hours guidance; information on reporting results in the emergency department; and service-level workflows that describe team member roles in the communication process.

When asked about challenges with the process to communicate test results, the radiology supervisor mentioned vacancies in the radiology department, as well as delays in receiving imaging results from the National Teleradiology Program.[32] The Chief of Staff attributed losing radiologists to the in-person work mandate. In response, leaders collaborated with other VISN facilities for radiology assistance. The Chief of Staff added that although VHA leaders have since exempted radiologists from the return to in-person work mandate, some left VHA and were unwilling to return. At the time of inspection in September 2025, the Chief of Staff reported trying to establish a contract for radiologists to further address the vacancies. In June 2026, the facility quality manager stated that a contract for radiologists was pending award for July 2026.

VHA Directive 1088(1) requires staff to communicate all test results that require action, including those that are urgent and noncritical, to patients within seven days after the results become available. Performance data for FY 2025 showed staff met this requirement 63 percent of the time for the first quarter, 53 percent of the time for the second quarter, and 55 percent of the time for the third quarter. In comparison, the VHA national averages were 81 percent, 81 percent, and 82 percent, respectively.

Further, the OIG found that although the Chief of Staff and ADPCS access performance data through reporting in the Quality Safety Value Committee, the ADPCS stated that leaders in different clinical areas review performance data for test result communication, instead of the Chief of Staff and the ADPCS, as required by VHA Directive 1088(1).

Recommendation 4

The Chief of Staff and Associate Director for Patient Care Services monitor performance data for test result communication, as required by Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

__X__Concur

_____Nonconcur

Target date for completion: Completed

[32] National Teleradiology Program radiologists provide image results to facilities when facility radiologists are unavailable (such as during evenings, nights, and weekends) or unable to meet test result deadlines. VHA Directive 1084, *VHA National Teleradiology Program*, April 9, 2020.

Director Comments

After completion of OIG HFI survey, the Chief of Staff (COS), Associate Director of Patient Care Services, and Quality Management (QM) reviewed VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023 (amended September 20, 2024), and the Albany local Medical Center Policy. A gap analysis was completed to ensure that the local policy was compliant with VHA Directive 1088(1). Due to the gap analysis and routine oversight of performance metrics, abnormal test results that require action compliance with directive increased from 52.38% to 90.48% in fiscal year 2026. Abnormal test results that require action communicated within 30 days of test report increased from 71.43% to 95.24% in fiscal year 2026, both surpassing VISN and VHA percentages. Communication of test results data is reported at QSV Committee quarterly in External Peer Review Program (EPRP) report. We are requesting closure of this recommendation.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders had completed improvement actions and therefore closed the recommendation before the report's publication.

Action Plans and Process Improvements

The systems redesign coordinator described efforts to incorporate a culture of continuous process improvement throughout the organization and include nonclinical staff in projects. For example, in 2024 a food service worker completed an improvement project in which staff reduced the number of soiled rags left out in the kitchen area, to address concerns about the unsanitary conditions these rags created. In another example, the quality manager stated that in 2025, the chief of VA police and a veteran justice outreach officer trained over 1,000 community police officers to recognize veterans in mental health distress and assist in providing appropriate help as an alternative to an arrest. Following the training, police officers brought at least 74 veterans to the facility's emergency department. The systems redesign coordinator reported helping staff with their individual improvement projects during monthly Continuous Process Improvement Lunch Meet and Learn meetings.

When asked about any issues related to patient safety that had not been discussed, a facility leader described frustrations about reporting and follow-up for concerns related to the quality of care veterans receive in the community.[33] The leader explained that when staff report an community care incident or concern in the Joint Patient Safety Reporting system (a VA database), the report goes to the third-party administrator for investigation, and facility staff do

[33] 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.

not get detailed information about the outcome because the third-party administrator is not contractually required to disclose these results.[34]

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[35] 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

At the time of the inspection in September 2025, facility leaders reported they manage 29 primary care teams and had vacancies for one provider, one registered nurse, three licensed practical nurses, and five medical support assistants. The principal facility coordinator stated that the facility contracts primary care services at four additional clinics to increase access to care, clinic space, and staffing. The deputy chief of staff reported relying on the Clinical Resource Hub to cover a provider vacancy that was unfilled for the past two years due to unsuccessful recruitment efforts.[36]

In June 2026 the facility quality manager provided primary care staffing updates, informing the OIG that although the provider position remains vacant, there is a potential candidate in recruitment. Additional current hiring actions include four registered nurses, two licensed practical nurses, and two medical support assistants.

The OIG team determined that 12 provider panels (patients assigned to a primary care team) exceeded the size recommended in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, with 2 panels operating at 181–228 percent of the

[34] VHA, Office of Integrated Care, *Patient Safety and Quality Frequently Asked Questions*, March 6, 2025. The OIG shared concerns in previous reports that the limited information third-party administrators provide to facility leaders regarding the outcomes of reported events could negatively affect their oversight to ensure patients receive quality care. VA OIG, *Care in the Community Inspection of South Central VA Health Care Network (VISN 16) and Selected VA Medical Centers*, Report No. 24-00823-68, March 20, 2025; VA OIG, *Care in the Community Inspection of Medical Facilities in VISN 17: VA Heart of Texas Healthcare Network*, Report No. 25-00107-75, March 18, 2026. On December 15, 2025, VA "released a request for proposals (RFP) for new community care contracts" to improve the quality of veterans' care and improve "VA oversight of Community Care." VA, "VA to Improve Health Care Choice and Quality for Veterans with New Community Care Contracts," (news release), December 15, 2025, https://news.va.gov/press-room/new-community-care-contracts.

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

[36] Clinical Resource Hubs are VISN programs that assist local VA facilities by providing clinical services to veterans through telehealth or in-person visits. "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/primarycare/CRH.

recommended size and the others at 101–149 percent.[37] Despite these panel sizes, the team found that from quarter three of FY 2024 through quarter three of FY 2026, new primary care patients consistently received appointments in less than 20 days. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the primary care wait time is longer than 20 days.[38]

Primary care staff said their immediate supervisors were supportive of patient care and staffing concerns, but additional support from executive leaders to increase staffing levels would enhance the quality of care and reduce burnout. Additionally, nurse managers were responsible for both clinical and leadership duties, while registered nurses often covered multiple roles, which strained resources and could give the impression that no additional staffing was needed.

Community Care Staffing and Access to Care

Community care staff and the program director voiced concerns related to increased workload because the number of community care referrals had increased by 19 percent from July 2024 to July 2025. Other leaders attributed the heavier workload to the loss of facility providers in services such as cardiology and radiology, which increased demand.[39] Community care leaders reported they had enough nurses, but lost seven or eight administrative staff during the hiring freeze. In August 2025, the chief of community care reported actively hiring for three of six vacant medical support assistant positions. As of June 2026, the facility quality manager stated that community care leaders had filled the three vacant positions and did not plan to hire additional staff.

Most patients referred to the community for wait time eligibility criteria were for imaging and radiology and dermatology services. The OIG team reviewed community care referrals from October 1, 2024, through July 31, 2025, and found that community care staff took an average of 8 days to schedule imaging and radiology appointments, and 15 days for dermatology appointments. On average, veterans waited 22 days for imaging and radiology and 37 days for dermatology services in the community.

VHA's *Consult Timeliness Standard Operating Procedure* requires community care staff to schedule appointments for veterans within 7 days of receiving a referral.[40] The chief of health administrative services said the primary barrier to meeting scheduling timelines was that facility community care staff had to make many telephone calls to community providers, which could

[37] VHA's baseline primary care team capacity is 1,200 patients for physicians and 900 for nonphysician providers. VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[38] 38 C.F.R. § 17.4040 (2025).

[39] *Merriam-Webster*, "Cardiology," last updated May 4, 2026, https://www.merriam-webster.com/cardiology.

[40] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," December 1, 2022.

delay appointments by weeks. Although VHA now allows community care staff to schedule appointments directly through community providers' systems, the chief pointed out that many large medical practices are unwilling to grant access.

Community care staff acknowledged that executive leaders had approved additional staff and overtime to manage increased workloads. Additionally, to improve processes, community care staff implemented a tracker board to enhance communication between nurses and medical support assistants.

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.[41]

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 homeless veterans who received an HCHV program intake assessment.[42] 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

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

[42] 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.

residences for veterans with mental health or substance use conditions).[43] 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)."[44]

Performance and Improvement Highlights

- The facility met the intake assessment (HCHV5) target in the first and second quarters of FY 2025. Facility program staff stated that teamwork and outreach helped them reach the goal.
- Staff described an FY 2025 summer surge event with community partners to identify and connect unsheltered veterans to housing resources. As a result, one veteran acquired permanent housing 10 days later.
- The facility also met the discharge to permanent housing (HCHV1) target in the first and second quarters of FY 2025. A staff member attributed this success to contacts with property managers and landlords, community partners who offer housing, and program staff who identified additional housing options.
- The facility also successfully met the negative exit (HCHV2) target in the first and second quarters of FY 2025. A staff member said this was due to good relationships with enrolled veterans and contract staff; staff also helped veterans who struggle with sobriety access treatment.

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."[45] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[46]

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

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

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

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

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[47]

Performance and Improvement Highlights

- The facility did not meet the voucher use (HMLS3) target for FY 2024. However, performance improved, with over 80 percent voucher use in quarters one and two of FY 2025. Facility program staff cited increased staffing, which expedited the voucher process, as a contributing factor. Also, the local housing authority raised voucher payment amounts, and program staff successfully engaged with landlords willing to rent to enrolled veterans.
- The facility exceeded the employment (VASH3) target in the first and second quarters of FY 2025. Staff said the community employment coordinator regularly met with veterans to help them write résumés, identify job opportunities, practice interview skills, and apply for Social Security disability benefits. Staff hosted job fairs, partnered with more employers, and expanded employer council meetings (attended by local employers to discuss job opportunities for 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.[48] 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).[49]

Performance and Improvement Highlights

- Facility program staff met the enrollment (VJP1) target in the first two quarters of FY 2025, which they attributed to connecting with community partners and

[47] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

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

[49] 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.*

providing outreach to ensure veterans are aware of the program. Staff at jails, prisons, courts, and community agencies referred veterans to the program.

- As an example, staff shared the story of a veteran who had been living under a bridge and became involved in a physical altercation. Instead of arresting the veteran, local law enforcement personnel brought them to the facility for evaluation.

Conclusion

To assist leaders in evaluating the quality of care at the VA Albany Healthcare System, the OIG conducted an inspection across five domains. The OIG made four recommendations related to privacy, cleanliness, and test result communications. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 4. The OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[50] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected the facility from September 23 through 25, 2025, and received an update from the facility in June 2026. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[51] 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.*[52]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[53] The OIG acknowledges potential bias because the facility liaison selected staff 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.

[50] The accreditation reports covered the time frame of October 1, 2023, through August 31, 2025—the most recent available at the time of the inspection.

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

[52] 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.

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

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[54] 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.

[54] 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: September 8, 2026

From: Network Director, VISN 1 (10N1)

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

To: Director, Office of Healthcare Inspections (54HF04)

Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the VA OIG Draft Report - Healthcare Facility Inspection of the VA Albany Healthcare System in New York. I have reviewed the document and concur with the recommendations noted.
2. The leadership teams at the VA Albany Healthcare System and the Veterans Integrated Network Office are committed to implementing Corrective actions and will diligently pursue all measures to ensure safe, high-quality care for the Veterans we serve.

(Original signed by:)

Ryan Lilly, MPA
Network Director, VISN 1

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2026

From: Director, VA Albany Healthcare System in New York (528A8)

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

To: Director, VISN 1 (10N1)

Thank you for the opportunity to review the draft report of the VA OIG draft report, Healthcare Facility Inspection of the Albany Healthcare System in New York. I have reviewed the document and concur with the recommendations noted.

(Original signed by:)

Darlene Delancey, MS
Executive Medical Center Director

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Rondina Marcelo, LCSW, Team Leader Laura Harrington, DBA, RN, Project Leader Joseph Giries, MHA, Director Shelia Farrington-Sherrod, MSN, RN Nancy Krzanik, MSN, RN Veronica Leon, PhD, MSN Temekia Toney, LCSW, MSW
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Christopher D. Hoffman, LCSW, MBA Amy McCarthy, JD Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

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