US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA NY Harbor Healthcare System in New York

Healthcare Facility Inspection	26-00053-273	September 23, 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 NY Harbor Healthcare System (the facility) from March 16 through 19, 2026. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 44,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG team found multiple issues at the Manhattan medical center's emergency department and dental clinic. They included exposed plywood, stained ceiling tiles, gaps between ceiling tiles, damaged floors, a broken door latch, rust, chemicals and supplies stored under sinks, dirt and debris, and corrugated boxes. VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to maintain a safe, clean, and functional healthcare environment.[3] In addition, the team found a lack of privacy in the emergency department, including two stretchers sharing one patient bay area and a glass-enclosed interview room labeled "Psychiatrist." The Joint Commission standard, Rights and Responsibilities of the Individual 01.01.01 requires hospitals to respect patients' privacy rights.[4] The OIG made two recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify

[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack-Operational Statistics Table FY2025," VHA Support Service Center, last updated February 23, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

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

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

[4] The Joint Commission, *Standards Manual*, E-dition, RI [Rights and Responsibilities of the Individual] 01.01.01, July 1, 2025.

opportunities for improvement. The OIG team found the facility did not have service-level workflows that identify all team members involved in communicating test results for all specialty care services, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[5] 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.[6] 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 Medical Center Director takes appropriate action so emergency department and dental clinic staff maintain a clean and safe environment and repair or replace damaged items to support effective disinfection, as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.
2. The Medical Center Director takes appropriate action so emergency department staff establish and maintain an environment that protects patients' privacy, as required by the Joint Commission standard, Rights and Responsibilities of the Individual 01.01.01.
3. The Medical Center Director takes appropriate action so all services develop workflows in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*, including defining responsibilities of non-provider personnel for communicating test results to patients.

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

[6] 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).[7] The OIG will follow up on the planned actions until they are completed.

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[7] 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

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
MRI	magnetic resonance imaging
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.[8] 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.[9]

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.[10]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[11]

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.[12]

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

[9] 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.

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

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

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

The VA NY Harbor Healthcare System (the facility) has three medical centers, located in Manhattan, Brooklyn, and Queens; two community-based outpatient clinics in Harlem and Staten Island; and two mobile clinics. In fiscal year (FY) 2025, the facility's medical care budget was approximately $955 million; it had 171 inpatient hospital, 23 domiciliary, and 142 community living center beds, and served approximately 44,000 veterans.[13]

Figure 1. *Margaret Cochran Corbin VA Campus in Manhattan, Brooklyn VA Medical Center, and St. Albans VA Medical Center in Queens, New York.*
Source: "VA New York Harbor Health Care," VA, accessed February 23, 2026, https://www.va.gov/new-york-harbor-health-care.

The OIG team inspected the facility from March 16 through 19, 2026. All three medical centers operate under a unified leadership structure with a single Medical Center Director overseeing the entire facility. The executive leaders referred to throughout this report include the interim Medical Center Director, Deputy Director, Chief of Staff, two Deputy Chiefs of Staff, Associate Director of Patient Care Services, Associate Director of Facilities and Operations, interim Associate Director for Security and Support Services, and an Assistant Director.

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

[13] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, accessed June 29, 2026, https://department.va.gov/homeless/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, accessed July 15, 2024, https://www.va.gov/CLC. "Trip Pack-Operational Statistics Table FY2025," VHA Support Service Center, last updated February 23, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[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

During an interview, executive leaders identified two recent system shocks: a burst pipe, which caused multiple leaks, and multiday snowstorms. Leaders reported they activated an incident command center—an emergency management system used by VA medical facilities to assign responsibilities and establish reporting channels between leaders and employees—during each event to ensure continuity of services.[17]

Executive leaders explained that several days of below-freezing temperatures in early February 2026 caused a pipe to burst at the medical center in Brooklyn. The resulting flood affected storage rooms, a primary care patient waiting area, public elevators, and a magnetic resonance imaging (MRI) machine.[18] Leaders reported the flooding did not spread to inpatient areas. After identifying the leaks and activating the incident command center, leaders instructed employees to reschedule patients who needed an MRI to the medical center in Manhattan because the casing around the machine required repairs and waterproofing to prevent future damage. After contractors completed the repairs, the OIG team confirmed that employees resumed scheduling patients for their imaging procedures in Brooklyn on March 27, 2026.

After the flooding event, forecasts predicted severe snowstorms that would affect the New York City area for several days. Because leaders received advance warning, they implemented the incident command center before the storms to coordinate with employees willing to come in early and provided overnight accommodation, food, and supplies. Employees also contacted patients in advance and rescheduled appointments. Two snowstorms affected the area, and patients who were discharged received follow-up phone calls 24 hours later. Executive leaders stated the incident command centers were instrumental in facilitating communication among services and providing updates to employees for both system shocks.

[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] VHA Directive 0320.12(1), *National Incident Management System Compliance*, December 8, 2020, amended January 25, 2021.

[18] "Magnetic resonance imaging (MRI) is a medical imaging technique that uses a magnetic field and computer-generated radio waves to create detailed images of the organs and tissues in your body." "MRI," Mayo Clinic, September 9, 2023, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

Employee Experiences

Over 40 percent of OIG questionnaire respondents indicated that facility leaders improved communication (see figure 2). However, employees also shared that leadership turnover (56 percent) and changes to structure or services (36 percent) disrupted daily operations. Executive leaders identified missed opportunities to communicate with employees about facility process changes and address uncertainty related to budget and hiring constraints in the year prior to the March 2026 inspection. Leaders stated their goal is to improve communication and engagement at all levels of the organization. To maintain visibility across the three medical centers, they spend two days each week in Manhattan, two days in Brooklyn, and one day in Queens. While on-site, leaders meet with employees in various areas to gather feedback.

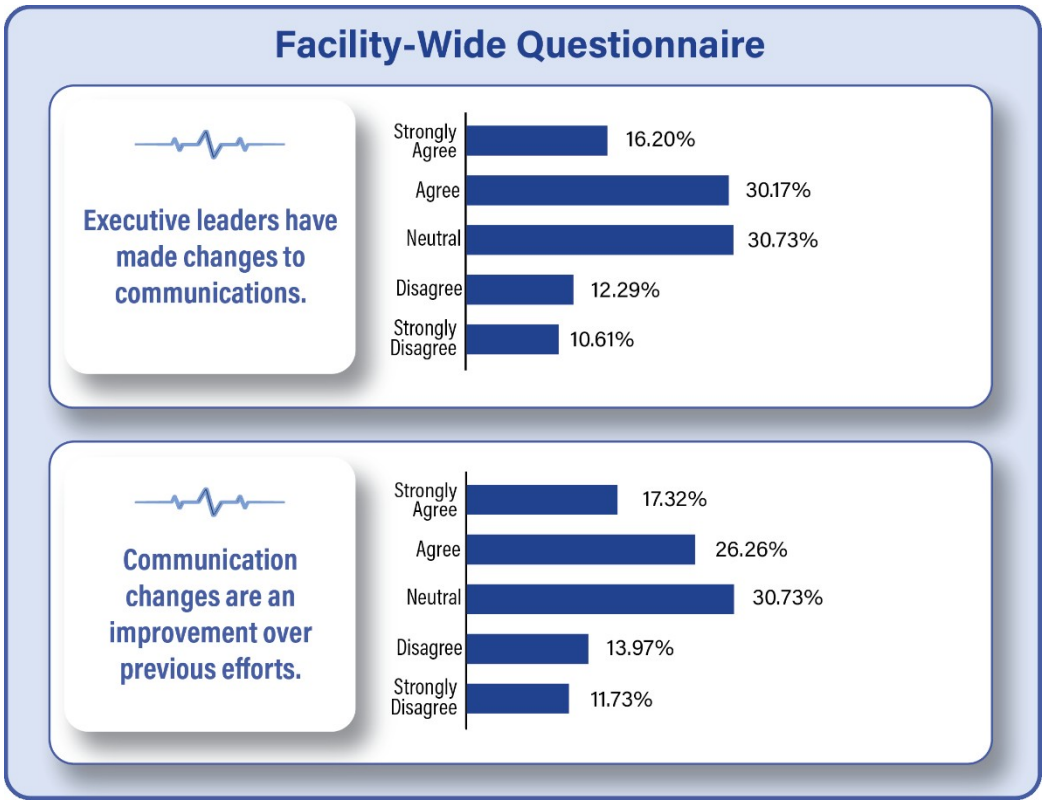

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Leaders also hold quarterly town halls, monthly employee recognition events, and daily huddles (meetings with all team members). In addition, they participate in monthly patient safety forums where employees discuss safety concerns. The facility chief wellness officer trained supervisors on effective communication, leadership skills, and change management and provided peer-to-peer support and presentations on burnout to employees.

The executive leaders told the OIG team that they had not sought documented feedback from employees. However, the interim Medical Center Director has consulted with the VHA National Center for Organizational Development about a formal process for collecting such feedback.[19]

Veteran Experiences

Executive leaders explained that veterans can share concerns and complaints with patient advocates or the patient experience officer, who works with services to resolve issues. If the issue remains unresolved, they elevate it to executive leaders. Veterans can also contact executive leaders directly through email or in-person meetings. The interim Medical Center Director participated in a resident meeting at the community living center and collaborated with veteran groups throughout the city. Additionally, the patient experience officer visits inpatient areas to gather feedback directly from veterans.

The OIG team reviewed documents from patient advocates showing veterans' three most common complaints were staff not answering telephones, not treating them with respect, and delaying their travel reimbursements. In response, executive leaders said they verified telephone numbers across the facility and are setting up a centralized phone center. They anticipate the new center will make scheduling easier for many veterans, though some may still prefer to speak with clinic staff directly.

To address concerns about respect, leaders piloted a *Compassion Counts* initiative in which they review the number and nature of complaints and then work closely with providers to improve veterans' experiences. They also encourage frontline employees to suggest ways to improve veteran interactions.

Executive leaders acknowledged challenges in the travel reimbursement process due to additional charges, such as tolls and congestion pricing, which are unique to New York City. The patient experience officer trained staff in the travel office on how to reconcile additional charges and avoid delays.

[19] "NCOD works with leaders to improve Veteran outcomes by increasing Employee Engagement through Organizational Development (OD)." "VHA National Center for Organizational Development," VA, accessed May 18, 2026, https://dvagov.sharepoint.com/sites/VHANationalCenterforOrganizationDevelopment. (This website is not publicly accessible.)

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[20] 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.[21]

General Inspection

The OIG team inspected the three medical centers. A response to an OIG questionnaire confirmed that public transit is available at each site and is a commonly used mode of transportation. The facility also operates a shuttle service that transports veterans between the three medical centers throughout the day. Additionally, each site has regular parking as well as accessible spaces for individuals with disabilities.

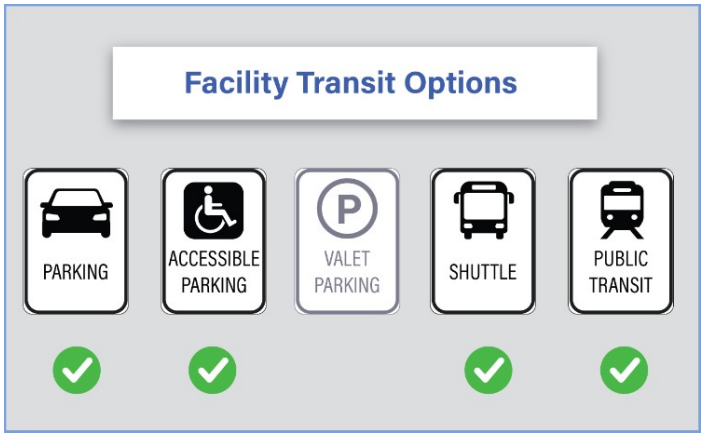

Figure 3. *Transit options for arriving at the facility. Source: Facility maps, shuttle schedule, and facility liaison responses to OIG questionnaire and questions.*

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

[21] 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.

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

All three main entrances have a covered entry with automatic double doors and wheelchairs readily available for use. The lobbies are well lit, with ample seating available. The Brooklyn and Manhattan sites have an information desk staffed by volunteers, whereas the site in Queens has a VA police officer posted at the entrance and requires visitors to sign in. Directional signs and maps guide veterans throughout each site. Through facility documents and observations, inspectors confirmed that assistive devices are available for individuals with sensory and other impairments (see figure 4).

The team physically inspected the community living center and inpatient and outpatient care areas and found them clean, well lit, and welcoming. Supply rooms and medication rooms were secure and contained no expired items. The OIG had no environment of care findings at the medical centers in Brooklyn or Queens.

However, at the medical center in Manhattan, inspectors noted multiple issues in the emergency department and dental clinic. In the emergency department, the team observed exposed plywood where laminate was missing from the desk at the nurses' station as well as dirty vents, stained ceiling tiles, damaged floor tiles, large cracks in the floor, and a broken latch on the isolation room door. In the dental clinic, inspectors noted rust on metal cabinets, chemicals and supplies stored under sinks, debris, numerous corrugated cardboard boxes, dirt under eyewash station dust covers, and a general lack of cleanliness inside the dental laboratory. The OIG team also observed food and drink at workstations in the laboratory. In two oral surgery rooms, the team noted gaps in the ceiling tiles directly over surgical chairs, rusted cabinets, and open plumbing cutouts.

VHA Directive 1608(1), *Comprehensive Environment of Care Program* requires facilities to maintain a safe, clean, and functional healthcare environment. VA's *Infection Control Standards for VA Dental Clinics* document prohibits food and drink in dental laboratories.[22] Additionally, damaged furnishings cannot be effectively cleaned and can harbor bacteria. Corrugated cardboard boxes can harbor pests and dust and increase fire load (potential heat energy if all

[22] VA, *Infection Control Standards for VA Dental Clinics*, revised June 8, 2026.

combustible materials in a space were to burn). Ceiling gaps pose contamination risks to sterile areas. Each of these issues poses a safety risk for veterans and employees.

The team reinspected the dental clinic the following day and found that leaders and employees had begun to address some of the identified concerns. However, the OIG made the following recommendation due to the nature of issues that had not been cited during the facility's recent comprehensive environment of care rounds or addressed by facility leaders.

Recommendation 1

The Medical Center Director takes appropriate action so emergency department and dental clinic staff maintain a clean and safe environment and repair or replace damaged items to support effective disinfection, as required by Veterans Health Administration Directive 1608(1), *Comprehensive Environment of Care Program*.

_X_ Concur

____ Nonconcur

Target date for completion: November 30, 2026

Director Comments

Immediate action was completed in March 2026 with the removal of all corrugated cardboard, under sink cleaning supplies and cleaning and restoration of affected areas. A new lower sink cabinet was ordered. Installation will be coordinated with Engineering and Dental Service. Tile replacement in the oral surgery room will be coordinated between Dental and Engineering Services.

Environmental Management Service (EMS) continues routine cleaning and floor refinishing in the Dental areas. EMS supervisors are performing weekly rounds to monitor cleanliness.

The monthly Environment of Care Committee (CEOC) meeting already includes a standing agenda item dedicated to OIG findings. The EOC Committee will continue to monitor the status of OIG-HFI corrective actions for 90% compliance for six consecutive months.

In the Manhattan emergency department, inspectors also noted a lack of privacy. The triage area is located directly next to the patient waiting area and the psychiatry interview room. Several areas contained two stretchers close together without a privacy curtain to separate the patients. The facility's privacy officer denied seeing two stretchers within one area during environment of care rounds. However, the emergency medicine chief reported having two stretchers per one area for at least six years.

Additionally, the emergency medicine chief and the associate chief of staff for psychiatry referred to the glass-enclosed psychiatrist interview room as "the fishbowl." A label posted next

to the glass door said "Psychiatrist." Patients inside the interview room lack privacy because they are visible from multiple angles both inside and outside the emergency department.

The Joint Commission's RI [Rights and Responsibilities of the Individual] 01.01.01 standard requires hospitals to respect patients' privacy rights.[23] The lack of privacy may make patients less likely to seek care for sensitive issues such as mental health, sexual trauma, or substance use. It may also cause them to feel anxious, vulnerable, and disrespected.

Recommendation 2

The Medical Center Director takes appropriate action so emergency department staff establish and maintain an environment that protects patients' privacy, as required by the Joint Commission standard, Rights and Responsibilities of the Individual 01.01.01.

__X__ Concur

____ Nonconcur

Target date for completion: November 30, 2026

Director Comments

The "fishbowl" triage area was identified as a visibility risk. ED leadership has adjusted workflow and added furniture to redirect sightlines. Engineering reviewed applicable VA design guidance—specifically VA PG-18-12, Emergency Department Design Guide, Sections 2.5.7.9 and 2.5.7.10—which provides for Mental Health Exam Rooms to be located adjacent to a nurse observation station and configured to permit direct clinical observation, including observation windows and door glazing with horizontal integral blinds controlled from the staff side.

To balance patient privacy with the clinical requirement for continuous staff observation, the medical center will install a horizontal blind on the exterior of the mental health screening room door and provide frosted glass on the door itself. The final configuration will preserve an unobstructed staff observation path while limiting visibility from public and non-clinical areas. Engineering, Mental Health, Nursing, Patient Safety, and Privacy staff will jointly review and approve the proposed corrective action before installation.

The OIG team noted that several areas contained two stretchers positioned close together without a privacy curtain to separate the patients. To correct this deficiency, the medical center ED staff immediately removed one stretcher from each affected bay so that each bay contains a single stretcher, eliminating the shared-space privacy concern without relying on a curtain or divider as a workaround. This change will be verified during CEOC rounds.

[23] The Joint Commission, *Standards Manual*, E-dition, RI [Rights and Responsibilities of the Individual] 01.01.01, July 1, 2025.

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

Communication of Urgent but Noncritical Test Results

The OIG team determined that the facility has processes, consistent with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, to communicate abnormal test results to providers and patients, assign a surrogate (substitute) when the provider who ordered the test is unavailable, and ensure providers communicate test results outside regular clinic hours.[24] During an interview, leaders and quality management employees stated that providers are responsible for notifying patients of test results. They outlined steps providers take to notify patients of results, including phone calls (repeated if necessary) and secure messaging; they also maintain up-to-date patient contact information. Providers are also required to verify their contact information every six months to ensure they receive test results. In addition, providers use software that automatically generates test result letters when phone calls are unsuccessful. Leaders explained that surrogate and backup reviewer processes ensure coverage when providers are unavailable or when physicians in training leave the facility.

However, the OIG team identified issues with service-level workflows. VHA Directive 1088(1) also requires each service to maintain workflows that identify all team members involved in communicating test results, including non-provider employees such as registered nurses, licensed practical nurses, and medical support assistants, and define their roles and the types of results they are authorized to communicate. Although the facility policy states that licensed or certified staff can provide test results that are not considered abnormal or critical to patients, inspectors found and leaders confirmed that several specialty care services lacked the workflows specifying the responsibilities of non-provider personnel.

Recommendation 3

The Medical Center Director takes appropriate action so all services develop workflows in accordance with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*, including defining responsibilities of non-provider personnel for communicating test results to patients.

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

_X_ Concur

____ Nonconcur

Target date for completion: September 30, 2026

Director Comments

The Chief of Staff reviewed the current facility standard operating procedure for the Communication of Test Results and will amend the SOP to identify workflow processes for reporting services (i.e. Pathology & Laboratory Medicine Service, Medical Service, Surgical Service, Primary Care, Emergency Department, Community Care) and ordering practitioners.

Action Plans and Process Improvements

The OIG team reviewed recommendations from prior oversight inspections and found no open (unimplemented) recommendations related to test result communications in the three years prior to the March 2026 inspection. Quality management employees explained that they track action plans through the Quality Committee, and services maintain trackers and collaborate with quality management employees to support compliance and sustainment. Quality management employees also monitor test result communications through the External Peer Review Program, share findings with service chiefs, and work with facility subject matter experts to determine the cause of any identified issues.[25] They also review data on test result communications in a monthly workgroup and a committee meeting.

Leaders and quality management employees described several methods for identifying improvement opportunities. In addition to reviewing entries in the Joint Patient Safety Reporting system (a database VA employees use to report safety events) daily, leaders use the *Good Catch* program to encourage employees to report close calls and promote a proactive culture of safety.[26] Leaders also conduct journal clubs to review research articles and share lessons learned as part of patient safety and improvement efforts. Quality management employees stated that executive leaders support patient safety through participation in huddles and safety forums.

[25] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

[26] VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting System] Guidebook*, Version 6.0, October 2025; Naseema B. Merchant, et al., "Development of a Safety Awards Program at a Veterans Affairs Health Care System: A Quality Improvement Initiative," *Journal of Clinical Outcomes Management* 30, no. 1 (January 2023): 9-16, https://doi.org/10.12788/jcom.0120.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[27] 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

VHA Directive 1101.10(2), *Patient Aligned Care Team (PACT) Handbook* requires primary care teams to have a provider, a registered nurse care manager, a licensed practical nurse, and a medical support assistant.[28] At the time of the inspection in March 2026, primary care leaders reported several staffing vacancies, especially among licensed practical nurses and medical support assistants. They attributed the medical support assistant vacancies to noncompetitive pay compared to community hospitals.

Primary care employees stated that the vacancies reduce operational efficiency and require cross-coverage and redistribution of work. Additionally, primary care employees and leaders raised concerns with the facility's self-scheduling platform, which allows veterans to make their own appointments; employees stated they review the week's schedule and address errors if observed. For example, leaders reported that male veterans were able to schedule appointments in the women's health clinic due to confusion about clinic names. Correcting these issues created additional work for the primary care teams.

However, according to facility documents, the vacancies have not affected access to care. The facility reported that in December 2025, new patients waited approximately 12 days for an appointment (the Code of Federal Regulations, title 38, section 17.4040 states that patients may be referred to community providers if the wait time is longer than 20 days).[29]

Community Care Staffing and Access to Care

In an interview during the OIG inspection in March 2026, community care leaders reported several medical support assistant vacancies in the program, which delayed scheduling patients'

[27] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care; VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[28] VHA Directive 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[29] 38 C.F.R. § 17.4040 (2025).

appointments. Leaders also said they are working with the Chief of Staff to hire for the vacant positions.

Leaders further stated that it took community care employees an average of nine days to schedule appointments, which exceeded the seven-day requirement stated in VHA's *Consult Timeliness Standard Operating Procedure*.[30] Facility documents showed that radiology was the top community care referral over the two years prior to the inspection due to staff vacancies and the flood-damaged MRI machine. Leaders meet monthly with the third-party administrator, who manages the contracts with community providers, to elevate any concerns such as record retrieval or difficulties with providers.

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.[31]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[32] HCHV2 measures the percentage of veterans who are discharged from the contracted emergency residential services or

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

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

[32] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: Fiscal Year (FY) 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens, a veteran can typically stay between 4 and 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[33]

Performance and Improvement Highlights

- The facility's program has a supervisor and six social workers. Program employees reported working closely with the New York City Department of Homeless Services, which operates the city's shelter system. The facility program also has a contracted residential program through the city's department, which includes 48 male and 8 female veteran beds. The program met the exit to permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2025.[34]
- Program employees identified a need for more contracted beds because the program often has a wait list. When no contracted beds are available, employees refer veterans to the Department of Homeless Services for a general population shelter bed.
- Additionally, program employees reported conducting outreach at places like Penn Station (with Amtrak and Metropolitan Transit Authority police departments) to identify and engage with veterans experiencing homelessness. When program employees are not on-site, Amtrak police notify them when they identify a veteran.
- The program also operates a walk-in clinic at two of the three medical centers. The Manhattan site serves an average of 130–150 veterans per month, while the Brooklyn site serves 12–16.

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."[35] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[36]

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

[34] For FY 2025, the facility's HCHV1 metric was 78.57 percent with a target of at least 55 percent, and HCHV2 was 14.29 percent with a target of below 20 percent.

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

[36] 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).[37]

Performance and Improvement Highlights

- The facility met both the voucher use (HMLS3) and employment (VASH3) targets for FY 2025.[38] Program staff attributed their success to fully using available resources to secure permanent housing, making multiple community referrals, and encouraging veterans to be engaged in the process. Staff said they assess veterans to confirm interest in employment before referring them to the facility's employment specialist.
- Employees stated the facility's program has six teams: two in Brooklyn; three in Manhattan, including an acute care team; and one in Queens. The teams have a coordinator and social workers; one team also has a housing specialist. The acute care team, which includes a nurse practitioner and a peer support specialist, helps veterans with medication management or care after a recent hospital discharge.
- Program employees reported managing 1,900 vouchers through their work with the New York City Public Housing Authority and the Housing Preservation Department. Employees average a case load of 25 actively enrolled veterans, as well as additional program graduates who no longer need case management but still use a housing voucher.
- Employees reported difficulty in locating senior housing. They said some sites have wait lists for as long as five years. Additionally, employees told inspectors that New York City has a unique requirement in which veterans who choose assisted living must relinquish their voucher.

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.[39] Recognizing incarceration as a strong predictor of

[37] 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.*

[38] For FY 2025, the facility's HMLS3 performance was 96.29 percent, and its VASH3 performance was 61.51 percent.

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

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).[40]

Performance and Improvement Highlights

- The facility met its FY 2025 enrollment (VJP1) target. The veterans justice outreach team attributed this to regular meetings about the performance measure and their practice of entering all assessments into VHA's tracking system.
- The facility program has a supervisor and two coordinators who serve veterans through 8 treatment courts (supervised programs that provide monitored treatment and other services), 11 jails, and 4 prisons in four of the five New York City boroughs (counties).[41]
- The team reported past difficulty with placing veterans in VA residential treatment programs because of stigma linked to incarceration. However, a centralized scheduling process seems to have removed the stigma barrier, and veterans are reviewed based on treatment needs rather than referral sources.

Conclusion

To assist leaders in evaluating the quality of care at the VA NY Harbor Healthcare System, the OIG conducted an inspection across five domains. The OIG made three recommendations related to the environment of care, privacy, and service-level workflows. 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.

[40] 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.*

[41] 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 OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from March 16 through 19, 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.[42] 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.*[43]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[44] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[45] The OIG reviews available evidence within a

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

[43] 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.

[44] 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.

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

specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2026

From: Director, New York/New Jersey VA Health Care Network (10N02)

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

To: Director, Office of Healthcare Inspections (54HF02)

Chief Integrity and Compliance Officer (10OIC)

Thank you for the opportunity to review the VA OIG Draft Report - Healthcare Facility Inspection of the VA NY Harbor Healthcare System in New York. I have reviewed the document and concur with the recommendations noted.

The leadership teams at the VA NY Harbor 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: Interim Executive Director, VA NY Harbor Healthcare System (630)

Subj: Initial Status Request-Healthcare Facility Inspection of the VA NY Harbor Healthcare System in New York

To: Director, VISN 1 (10N01)

I have reviewed the findings from the Office of the Inspector General Healthcare Facility Inspection of the VA NY Harbor Healthcare System in New York conducted March 16 to 19, 2026 and concur with the recommendations.

I am submitting the facility plan to correct these findings and will monitor for compliance.

I appreciate the OIG's review and look forward to our partnership for continued compliance and improvements.

(Original signed by:)

Felix Kunjukutty, MD
Interim Executive 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.