US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia

Healthcare Facility Inspection	24-00592-60	March 6, 2025

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA Dublin Healthcare System (facility) from April 16 through 18, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Staff and leaders identified leadership turnover as a system shock. After several executive leaders were reassigned from their positions in early 2024 (Director, Chief of Staff, and Deputy Chief of Staff), the executive leadership team consisted of acting and permanent staff. The OIG also found that key leader positions in several departments had acting staff due to leaders being reassigned from their positions due to various allegations of ineffectiveness. The Acting Director said the prior Director and the American Federation of Government Employees local chapter Union President were both recently arrested for non-VA related actions.

The Acting Director described a unique circumstance facing the organization. In March 2022, VA made a recommendation to the Asset and Infrastructure Review Commission to move the

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

facility to Macon, Georgia.[2] The Acting Associate Director pointed out that the facility is the top employer in a small rural community, and the Acting Director stated that moving the facility to Macon would create a travel hardship for local veterans and staff. Leaders said they addressed concerns noted in the commission's report by reestablishing beds and services that were reduced during the COVID-19 pandemic and planning to add a new clinic in Houston, Georgia, which will offer additional services in that location.

Additionally, despite leaders asserting they made improvements following an OIG hotline inspection and a recently published OIG report on deficiencies in sterile processing, there was a recent incident involving staff's improper processing of reusable medical equipment reported during the OIG visit.[3] Based on concerns with leadership challenges and the most recent sterile processing event, the OIG's Healthcare Facility Inspection team notified the OIG's hotline team and therefore did not make a recommendation in this report related to the event.

Based on OIG questionnaire responses, many employees did not think the culture was moving in the right direction but did feel comfortable suggesting actions for improvement. Executive leaders discussed how they enlisted support from Veterans Integrated Service Network and facility resources to support staff during times of change.[4]

Regarding veterans' experiences at the facility, the OIG reviewed a report with 15,247 issues that were submitted to the patient advocate's office over the past three years that indicated staff had resolved those concerns.[5] The Veterans Experience Officer described challenges with working relationships within the patient advocate's office. The Acting Director said patient advocate office staff received support from the Veterans Integrated Service Network psychologist and other resources to help them work together more effectively.

[2] Department of Veterans Affairs, *VA Recommendations to the Asset and Infrastructure Review Commission, VISN 07, Market Recommendations*, March 2022, https://www.va.gov/AIRCommissionReport/VISN7.pdf. The recommendations "are designed to modernize and realign VA health care facilities to improve access and outcomes for current and future generations of Veterans." "VA Recommendations to the AIR [Asset and Infrastructure Review] Commission, Volume II: Market Recommendations," Department of Veterans Affairs, accessed February 27, 2024, https://www.va.gov/AIRCommissionReport/Volume_II.asp. The report refers to the Dublin VA Medical Center, which is the same as the Carl Vinson VA Medical Center.

[3] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*, Report No. 22-01315-90, March 6, 2024.

[4] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[5] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were areas with recurring issues.

The OIG found exterior signs were difficult to read due to fading and insufficient light and requests facility leaders consider improving exterior signage visibility. The OIG also found that the two facility entrances and the long hallways had minimal to no seating available and witnessed several people entering the building seemingly tired or short of breath and looking for somewhere to sit.

The OIG observed several signs directing veterans to an emergency department, which the facility no longer had and recommends leaders correct outdated signs. The OIG also observed navigation options for veterans with visual and hearing sensory impairments but noted closed captioning was not always used on televisions in common area for those who are hearing impaired.

The facility had two assigned toxic exposure screening navigators. One navigator reported having no direction about the additional duty, and the Chief of Primary Care added that duties were spread across multiple staff members. The OIG found staff had not completed 457 toxic exposure screenings, so leaders assigned additional providers to contact the patients and complete them over the phone. The OIG recommends leaders define toxic exposure screening navigators' responsibilities and ensure program oversight.

During the general facility inspection, the OIG observed damaged floors at hallway intersections, damaged walls, and dirty areas. The OIG also found that some soiled utility rooms where staff store biohazardous materials had no sink or hand sanitizer nearby, no biohazard sign to warn staff of potentially infectious material, and contained housekeeping supplies. Additionally, staff had not identified any facility-specific environment of care trends to develop an action plan for improvement, as VHA requires.[6] The OIG made recommendations to address the deficiencies.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG noted a general lack of leadership oversight and accountability for

[6] Acting Deputy Assistant Under Secretary for Health for Operations, "Fiscal Year (FY) 2023 Comprehensive Environment of Care (CEOC) Guidance (VIEWS 9547420)," memorandum to Veterans Integrated Service Network (VISN) Directors, February 21, 2023.

test result communications until the current fiscal year. The OIG reported two patient complaints related to delays in communication of laboratory and radiology test results to facility leaders in 2022, which prompted staff to begin auditing the communication process for primary care that year. However, a patient safety manager discussed an aggregate root cause analysis, initiated in April 2024, that included 25 patient safety events related to communication of test results.[7] The OIG reviewed reports from the Joint Patient Safety Reporting system and found instances of delayed patient notification of abnormal test results.[8] The OIG found no sustained improvements on timely communication of tests results to patients and recommends leaders resolve this vulnerability. Facility leaders were aware of and acknowledged their lack of improvements.

The OIG also found that staff used outdated guidance. For example, when the OIG requested current policies, staff provided outdated VHA handbooks, instead of the most current versions, and a standard operating procedure that expired in 2021. The OIG issued a recommendation to address this concern.

The OIG reviewed the three institutional disclosures for adverse events that occurred in the past 12 months, two involving delayed communication of test results, treatment, or both.[9] The OIG found staff had not entered these events in the patient safety reporting system. The general lack of leadership oversight and accountability for test result communications was similar to a finding in the OIG's recently published hotline report about sterile processing deficiencies.[10] Due to the levels of concerns with leadership accountability, the OIG's hotline team will investigate further.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[11]

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[7] A root cause analysis is a comprehensive and focused review used for "adverse events and close calls" requiring analysis. A wild card aggregate root cause analysis is a type of root cause analysis conducted from multiple patient safety events that do not meet the criteria for individual root cause analysis and may include frequent events with upward trends. VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[8] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[9] An institutional disclosure is a "formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[10] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*.

[11] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

The Associate Director of Patient Care Services stated there were minimal challenges filling positions for nurses in primary care, and the Chief of Primary Care highlighted that all provider positions had been filled for the past eight months. Leaders added that the Houston clinic will have space for five new primary care teams.

Primary care staff reported no significant impact from the PACT Act implementation, and the OIG determined it had no effect on appointment wait times. Leaders added that although veteran enrollment had declined some, they expected it to increase when the new clinic opened. Staff reported feeling supported by leaders, who hired a new educator to train primary care staff and established a program to train new primary care nurses.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. Program staff reported receiving referrals to the homeless programs from various sources like the facility's mental health, community living center, and acute care staff; county programs and shelters; and local court, jail, and legal assistance staff.

The Health Care for Homeless Veterans Coordinator identified lack of affordable housing in the area as an ongoing issue. Veterans justice outreach staff described a future collaboration with the National Alliance on Mental Illness of Central Georgia on a new project that will build several tiny houses and accept veteran referrals.

Homeless program staff also identified lack of appropriate vehicles to conduct outreach as an issue. Leaders assigned four electric vehicles to the program, but the solar-powered charging stations did not work. Staff had to travel long distances and had difficulty locating charging stations in the predominately rural area. Although leaders were aware of the concerns and recently replaced two of the vehicles, the OIG recommends leaders ensure staff have appropriate work vehicles.

What the OIG Recommended

The OIG made eight recommendations for improvement.

1. Facility leaders review and correct any outdated navigational signage.
2. Facility leaders define and assign roles and responsibilities to toxic exposure screening navigators and ensure program oversight.
3. The Director ensures staff keep patient care areas safe and clean.

4. The Director ensures biohazard storage areas display proper signage, have appropriate hand-washing supplies and equipment available, and do not contain housekeeping supplies.
5. The Associate Director ensures staff identify one or more facility environment of care trends and establish a performance improvement plan, including outcome measures, to address them.
6. Facility leaders continue to develop and implement administrative processes to ensure ordering providers promptly communicate and document test results.
7. Facility leaders ensure staff maintain and reference current VHA requirements and update facility-level policies and standard operating procedures to comply with them.
8. Facility leaders ensure homeless program staff have access to appropriate vehicles to conduct their work.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Interim Executive Director concurred with the recommendations and provided acceptable action plans (see appendixes D and E, and the responses within the body of the report for the full text of the directors' comments). Based on information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

JULIE KROVIAK, M.D.
Principal Deputy Assistant Inspector General,
in the role of Acting Assistant Inspector General,
for Healthcare Inspections

Abbreviations

ADPCS	Associate Director of Patient Care Services
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA Dublin Healthcare System
Dublin, Georgia
Level 3-Low Complexity
Laurens County
Hospital Referral Region: Macon

Description of Community

POPULATION

Female **574,589**	Male **551,807**
Veteran Female **11,332**	Veteran Male **70,314**

Homeless - State **10,689**
Homeless Veteran -State **664**

MEDIAN INCOME

$45,577

EDUCATION

83% Completed High School
48% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **325**

SUBSTANCE USE

23.6% Driving Deaths Involving Alcohol
16.6% Excessive Drinking
127 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	380,041
Carpool	43,443
Work at Home	16,073
Other Means	7,427
Walk to Work	5,529
Public Transportation	2,123

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**32 Minutes, 26 Miles**
Specialty Care	**67 Minutes, 63.5 Miles**
Tertiary Care	**118.5 Minutes, 113.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 15,832

Veterans Receiving Teleheath (Facility)	43%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	19%

Health of the Veteran Population

2 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

14,275

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

7.35 Days

30-DAY READMISSION RATE

15%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
19	33

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	43K
Unique Patients VA Care	41K
Unique Patients Non-VA Care	23K

★ VA MEDICAL CENTER

VETERAN POPULATION

100 — 49,323

COMMUNITY CARE COSTS

Unique Patient $9,638	Outpatient Visit $240
Line Item $288	Bed Day of Care $124

STAFF RETENTION

Onboard Employees Stay <1 Yr	11.95%
Facility Total Loss Rate	9.49%
Facility Retire Rate	2.19%
Facility Quit Rate	6.83%
Facility Termination Rate	0.36%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection (HFI) cyclical review program to help accomplish its mission. HFI teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting

[1] "About VHA," Department of Veterans Affairs, accessed May 29, 2024, https://www.va.gov/health/aboutvha.asp.

specific actions they can take to improve patient safety and care.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022).

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA, accessed May 1, 2023, https://www.accesstocare.va.gov/pdf/VA_PACTActDashboard.pdf.

Content Domains

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The Carl Vinson VA Medical Center, part of the VA Dublin Healthcare System (facility), opened in 1948. At the time of the inspection, the facility's executive leaders consisted of acting staff in the medical center director, chief of staff, and associate director roles. The Assistant Director and Associate Director of Patient Care Services (ADPCS) were permanently assigned; however, the ADPCS was reassigned from the position approximately two months after the OIG visit.[13] In fiscal year (FY) 2023, the facility's budget was approximately $527 million. The facility had 345 operating beds, which included 36 hospital, 164 community living center, and 145 domiciliary beds.[14]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[17]

[13] For more information about leader turnover, see the System Shocks section below.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv.asp.

[15] 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.

[16] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

[17] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

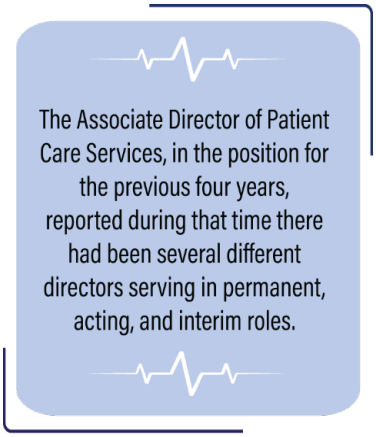

Figure 4. *Facility systems shock. Source: OIG interviews.*

In the OIG's facility-wide questionnaire, most respondents identified turnover in key leadership positions as a system shock over the past three years. At the time of the OIG's visit, the executive leadership team consisted of acting and permanent staff. The Associate Director was covering the director position, and the Chief of Logistics—who planned to transfer soon to work at another VHA facility—was covering the associate director position. The prior Chief of Staff and Deputy Chief of Staff were reassigned to other positions in February 2024, and the prior Director, reassigned to another position in January 2024, resigned in March 2024.[20] The ADPCS, Deputy ADPCS, and Assistant Director had permanent appointments.[21]

In addition, the OIG found that key leader positions in several departments had acting staff due to previous leaders being reassigned pending review due to various allegations of ineffectiveness. The OIG had concerns when one of these leaders represented themself as still in the role. The Chief, Health Administrative Services, who was detailed to a different position just prior to the OIG site visit, attended OIG interviews and introduced themself as the leader for that service. The OIG did not learn until later in the week that the chief position was filled by an acting person.

The OIG determined that, due to the recent reassignments of key leaders, the facility was in a state of transition that current leaders were trying to navigate. The Acting Director reported that

[18] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[19] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies"; Department of Veterans Affairs, *VHA HRO Framework*.

[20] Executive Leaders were reassigned pending review due to various allegations of ineffectiveness and the director, chief of staff, and deputy chief of staff positions were covered by assigned staff.

[21] The ADPCS and Deputy ADPCS were reassigned pending review in June and July 2024, respectively.

the prior Director and the American Federation of Government Employees local chapter Union President were both recently arrested for non-VA related actions. The Acting Director reiterated the leadership changes had been the largest system shock because some of the reassigned leaders had long tenures.

The Acting Director also described a unique circumstance facing the organization. In March 2022, VA recommended to the Asset and Infrastructure Review Commission to move the facility to Macon, Georgia, due in part to aging infrastructure and geographic distribution of the veteran population.[22] The prior Director held a town hall to discuss the proposal to relocate the facility and address any staff concerns. The Acting Associate Director explained to the OIG that the facility is the top employer in a small rural community, and the Acting Director stated that moving the facility to Macon would create a travel hardship for local veterans and staff.

To keep the facility in its current location, the Acting Director said executive leaders reestablished beds and services that were reduced during the COVID-19 pandemic and planned to add services closer to veterans' homes. For example, the Acting Deputy Chief of Staff discussed the approval to open a new clinic in Houston, Georgia, which will result in five new primary care teams and increase access to services, such as women's health and chiropractic care in that location.[23]

Leaders shared that the facility was a large part of the community, so unlike in bigger cities, any news may be a major event. Due to the leadership changes and concerns over the commission's report, leaders described how they support staff through improved communication and increased psychological safety, as discussed later in the section.[24] Leaders reported enlisting help from a Veterans Integrated Service Network (VISN) psychologist, the facility's wellness coordinator, and mental health staff to also support staff through these transitions.[25] The ADPCS mentioned

[22] Department of Veterans Affairs, *VA Recommendations to the Asset and Infrastructure Review Commission, VISN 07, Market Recommendations*, March 2022, https://www.va.gov/AIRCommissionReport/VISN7.pdf. The recommendations "are designed to modernize and realign VA health care facilities to improve access and outcomes for current and future generations of Veterans." "VA Recommendations to the AIR [Asset and Infrastructure Review] Commission, Volume II: Market Recommendations," Department of Veterans Affairs, accessed February 27, 2024, https://www.va.gov/AIRCommissionReport/Volume_II.asp. The report refers to the Dublin VA Medical Center, which is the same as the Carl Vinson VA Medical Center.

[23] According to the ADPCS, when the Houston clinic opens, they will close the Perry VA Clinic, which currently has three primary care teams.

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

[25] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

that it takes time to change an organization's culture, while the Acting Director stated that the change begins with leaders and cascades down, in a deliberate process.

Despite leaders' assertions that they made improvements in response to organizational challenges, the OIG found they continued to have issues regarding sterile processing. In March 2024, the OIG published a report highlighting improper sterile processing of reusable medical equipment at the facility, and the sterile processing service's history of unstable leadership as a potential failure point.[26] The ADPCS stated that leaders had since made sterile processing improvements, and staff began sharing best practices with other facilities. However, during this inspection, the OIG attended a daily leadership briefing and learned of a recent incident involving staff's improper processing of reusable medical equipment used in patient care. Facility staff were still investigating the event, which is discussed further in the Patient Safety section of this report. The OIG's HFI team immediately reported this event to the OIG's hotline team, who conducted the sterile processing services inspection, and therefore did not make a recommendation in this report.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[27] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[28] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[29] The OIG reviewed VA's All Employee Survey data and

LEADER COMMUNICATION
Executive leaders identified huddles, town halls, and their presence in clinical areas as initiatives they have taken to improve communications.

LEADER INFORMATION SHARING
The Acting Director reported interacting more face-to-face, opening the morning report meeting to all senior level leaders, and sharing information and data with all staff to help guide actions and decision-making.

Figure 5. *Leader communication with staff.*
Source: OIG analysis of interviews with facility leaders.

[26] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*, Report No. 22-01315-90, March 6, 2024.

[27] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[28] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[29] The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[30]

The OIG's questionnaire showed more respondents were neutral or disagreed that leaders had made changes to communication. All Employee Survey scores for leadership transparency remained similar from FY 2021 through FY 2023 and were below VHA averages for these years. However, executive leaders gave examples of recent efforts they made to improve communication and transparency, such as holding town hall meetings, making service and frontline leaders responsible for improving communication and transparency in their areas, and visiting frontline staff in their work areas.

[30] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[31] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[32] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

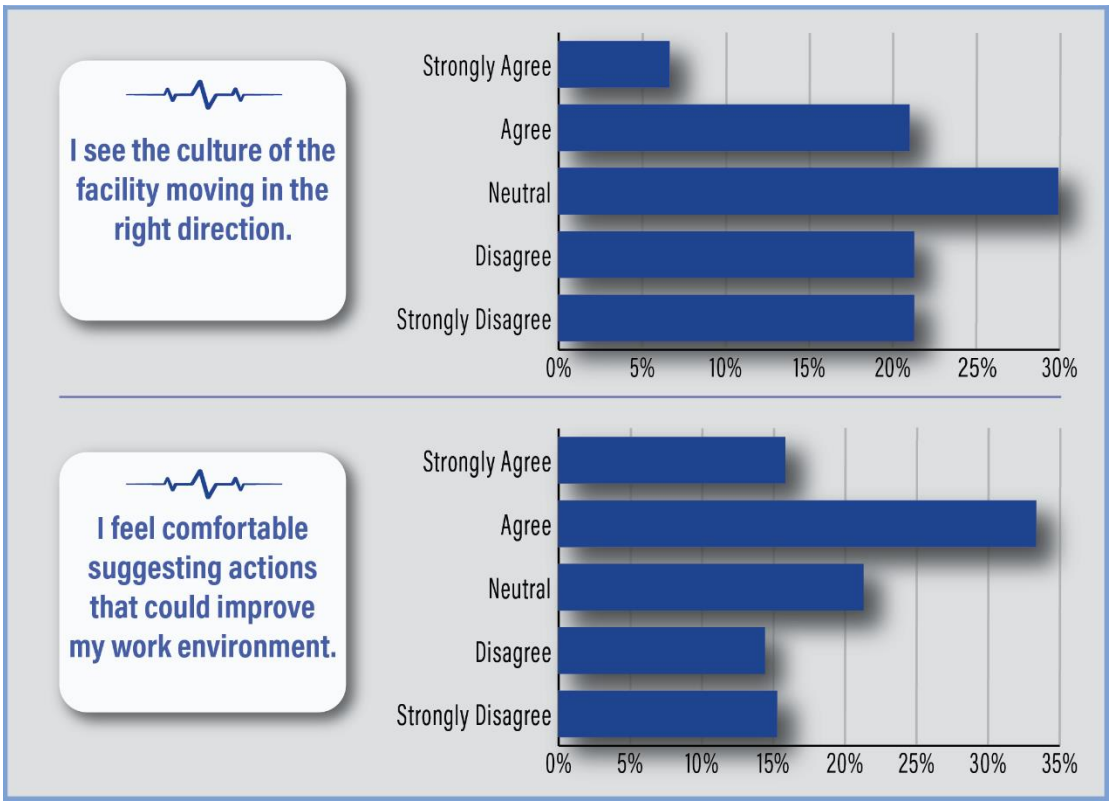

Figure 6. *Employee perceptions of facility culture.*
Source: OIG questionnaire responses.

The OIG's questionnaire showed that, in general, many respondents did not think the culture was moving in the right direction but did feel comfortable suggesting actions for improvement. Responses also revealed that pay and benefits and the VA mission are what kept employees working at the facility, while bad leadership, followed by stress and burnout, made them consider leaving. The executive leaders described the key drivers of accountability, growth, and communication as essential to changing the facility's culture. To improve communication and

[31] Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout."

[32] Ravinder Kang et al., "Association of Hospital Employee Satisfaction with Patient Safety and Satisfaction within Veterans Affairs Medical Centers," *The American Journal of Medicine* 132, no. 4 (April 2019): 530–534, https://doi.org/10.1016/j.amjmed.2018.11.031.

accountability, the Acting Director said leaders changed their daily briefings to include attendance by service leaders to promote consistency of information sharing.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. Many employees responded positively on the survey to feeling comfortable suggesting improvements, and the executive leaders emphasized using support services, like the VISN psychologist, and initiatives to improve transparency and communication to increase employees' feeling of psychological safety.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[33] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[34] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility. The OIG also reviewed questionnaire responses from a Veterans Experience Officer and interviewed the officer and executive leaders.

The VSO responses described professional and timely communication with facility staff. Executive leaders reported active involvement with local VSOs, sharing that one group had recently disbanded, sold their assets, and donated the proceeds to the facility.

The Veterans Experience Officer, who recently transferred from another VHA facility, reported challenges with the patient advocate's office, citing leaders' lack of support for improving the working relationships in the patient advocate's office and not addressing veterans' concerns reported to the office. However, the OIG reviewed a report that showed 15,247 issues submitted to the patient advocate's office over the past three years, which included veterans' concerns about access to care, billing, eligibility, and coordination of care, that had been resolved. The Acting Director described efforts to improve working relationships among staff who work in the patient advocate's office by supporting them with assistance from the VISN psychologist and other resources to help them work together more effectively.

[33] "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

[34] Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[35] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo.*
Source: "VA Dublin Health Care," Department of Veterans Affairs, accessed April 22, 2024, https://www.va.gov/dublin-health-care/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[36] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[37]

[35] VHA Directive 1608(1).

[36] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

[37] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Transit and Parking

The ease with which a veteran can reach the facility's location is part of the healthcare experience. The OIG expects the facility to have sufficient transit and parking options to meet veterans' individual needs.

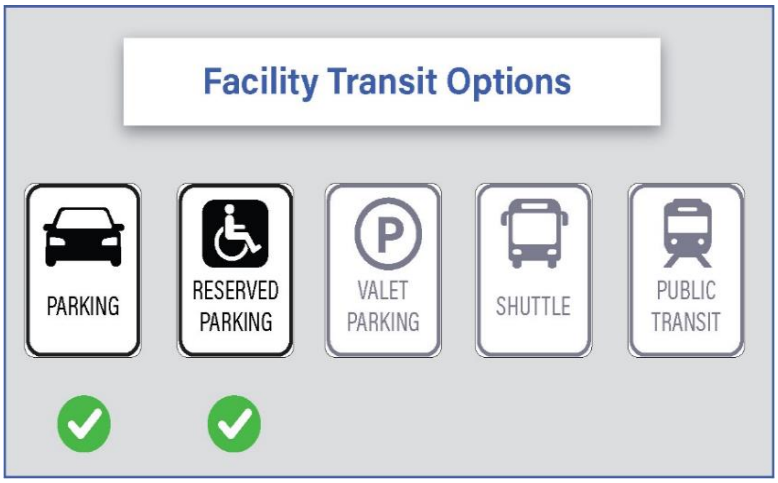

Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG inspection team used two commercial navigation applications to travel to the facility and found the instructions easy to follow. Upon arrival, the OIG observed parking available, including spaces accessible for those with disabilities. The OIG identified two entry points onto the facility's campus from public roads; the exterior signage at the Veterans Boulevard entrance was weathered and difficult to read (see appendix C, figure C.1), and the sign at the other entrance lacked lighting for visibility at night or during inclement weather. The OIG requests that facility leaders evaluate and consider taking actions to improve exterior signage visibility.

The campus had multiple connected buildings, and the OIG evaluated two commonly used entrances in building 1 and 5. The administrative entrance was in building 1, which veterans could access from Veterans Boulevard. Parking for the entrance was not adjacent to the building and had lighting in the lots. The entrance for building 5 was adjacent to the Urgent Care Center and close to outpatient clinic areas. Its parking lots, located near the entrance, had lights and security cameras.

Public transportation was not available in the Dublin area; however, the Safety, Grounds, and Transportation Supervisor reported that a VSO (Disabled American Veterans) provided a van service to transport veterans to scheduled medical appointments. Additionally, the supervisor explained that some veterans may qualify for VA travel benefits, which include round-trip transportation from their home to the facility.

Main Entrance

Figure 9. *Building 5 entrance.*
Source: Photo taken by the OIG team.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[38]

The OIG noted that buildings 1 and 5 entrances had power-assisted doors, available wheelchairs, and an information desk staffed by volunteers. Building 5's entrance was crowded, noisy, and did not have a sitting area except in the Urgent Care Center waiting room, which was locked when the center was closed.[39] Although additional seating was available at a vending area down the hall, the area was dirty and disorganized.

Initially, staff told the OIG that two different services were responsible for managing the area, but neither service leader took ownership. Later, an executive leader explained the staff from the Veterans Canteen Service (responsible for retail stores, cafés, and coffee shops in VA facilities) managed the vending area. Because staff cleaned and organized the area while the inspection team was on site, the OIG did not make a recommendation but encourages facility leaders to ensure this space remains clean and orderly.

The building 1 entrance also lacked a sitting area, so veterans had no place to rest after walking the longer distance from the parking lot. The OIG further noted minimal to no seating available throughout the facility's long hallways (see appendix C, figure C.2 for a facility map). The OIG witnessed several people entering the building tired or short of breath and looking for somewhere to sit. The OIG requests that facility leaders evaluate seating options and consider adding seats to allow people opportunities to rest.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[40]

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[38] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

[39] The Urgent Care Center's hours of operation were 8:00 a.m. to 8:00 p.m.

[40] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

The OIG team found large-print maps available, instructions on how to download a free mobile map application, and two kiosks to assist with navigation near both entrances inspected. However, the OIG noted these materials and devices were not up to date, and the printer did not work at one of the kiosks. The customer service representative explained there was no official process to update the kiosk and mobile application when staff relocated areas; instead, they usually provided directions verbally. The representative added that a contractor updated the kiosks because staff had not been trained for this task. The OIG requests facility leaders consider establishing a process to update paper maps, the mobile map application, and kiosks after relocating areas.

The OIG also observed multiple inaccurate navigational signs throughout the facility. For example, several signs indicated the emergency department was straight ahead, but the facility no longer had an emergency department (see appendix C, figure C.3). Internal navigational signs were also not consistently placed at decision points (a location where a person must choose whether to continue along the current route or change direction), making it difficult to find specific areas without asking for assistance. The OIG recommends facility leaders review and correct any outdated navigational signage.

Additionally, multiple hallway intersections did not have mirrors. The use of specially designed mirrors can help to reduce blind spots and reduce collisions when crossing hallway intersections. The OIG requests that facility leaders consider evaluating and improving hallway intersection safety.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[41] The OIG observed check-in kiosks had an option for visually impaired veterans to use their own headphones with the device. Map kiosks allowed veterans to increase text and map size on the screen for

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of observations, documents, and interviews.

[41] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

ease of reading. Information desk volunteers reported they would help those with visual impairments get to their location; they could communicate in writing; and although they could not communicate using sign language, there was a translation service available.

The OIG noted there were no sound absorbing panels on the walls at either entrance, and the spaces were noisy, which could affect individuals who are hearing impaired. Televisions had closed captioning capability, but the OIG team did not see it in use on any televisions in common areas. The OIG requests that facility leaders consider using closed captioning on televisions in common areas.

Toxic Exposure Screening Navigators

VA required each facility to identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[42]

The OIG reviewed materials regarding toxic exposure outreach activities held at the facility and in the community. While no informational handouts on toxic exposure screening were available to the public at the information desks, the Nurse Manager of Primary Care reported that staff provided the handouts during patients' appointments.

The OIG learned the facility had two staff identified as toxic exposure screening navigators, but they had limited responsibility in the role. One navigator reported that it was an additional duty with no clear direction about assigned responsibilities. The Chief of Primary Care explained navigator functions were spread out across multiple other staff members. For example, a primary care staff member reviewed screening completion data.

At the time of the inspection, facility staff had not completed 457 toxic exposure screenings. The Chief of Primary Care explained some providers were overwhelmed with completing the screenings, so leaders had begun assigning other providers to contact the patients and complete them over the phone. The OIG is concerned this lack of defined responsibilities and division of labor created a lack of oversight of the toxic exposure screening program. The OIG recommends facility leaders define and assign roles and responsibilities to toxic exposure screening navigators and ensure program oversight.

[42] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[43]

The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues. The OIG did not identify any repeated environment of care findings for the areas evaluated and made no recommendations.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected several clinical areas and noted there were clear exit paths, no visible protected patient information, and medical equipment had current inspection stickers.[44] However, the OIG observed multiple cracks in the hallway floor joints throughout the facility, which could pose a tripping hazard. Additionally, the OIG observed unrepaired holes in walls and others that were patched but not painted, as well as dust on bottom frames of beds and on shelves in clean supply rooms.

In a community living center neighborhood, the OIG observed a dirty and cluttered common area that contained staff belongings and patient food stored in a cabinet that also held cleaning supplies.[45] The medication room in another neighborhood was cluttered and contained expired supplies and corrugated boxes.[46] In the community living centers' patient food storage areas, the OIG noticed expired food, a rusty sink, a dirty microwave, and hard deposits on an ice machine.

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[43] Department of Veterans Affairs, *VHA HRO Framework*.

[44] The OIG inspected the following patient care areas: three community living center neighborhoods (Magnolia Lane in building 12, Old Timers' Lodge in building 10, and Patriots Point in building 17); a medical/surgical inpatient unit (building 15); an outpatient clinical area (Green Team in building 5); and the Urgent Care Center (in building 5). The OIG did not have the opportunity to observe patient rooms in the community living center neighborhoods because none were vacant. Additionally, two neighborhoods (Cardinal Circle and Freedom Lane in building 8) had several residents who tested positive for COVID-19, so the OIG did not inspect these areas.

[45] The OIG observed these deficiencies in the Magnolia Lane neighborhood.

[46] Corrugated boxes are an infection control concern because they can house pests, droppings, and larva, which can lead to an infestation. "What is The Joint Commission's Position on Managing Cardboard or Corrugated Boxes and Shipping Containers?," The Joint Commission, accessed November 4, 2024, https://www.jointcommission.org; VHA Directive 1761, *Supply Chain Management Operations,* December 30, 2020. The OIG observed this medication room in the Old Timers' Lodge neighborhood.

The OIG also observed personal protective equipment stored at the ends of hallways and not readily accessible near patient rooms.[47]

Further, the OIG found the Urgent Care Center's soiled utility room, where staff store biohazardous materials, did not contain a sink or have hand sanitizer nearby, preventing staff from immediately cleaning their hands; the medical/surgical unit's soiled utility room lacked a biohazard sign to warn staff of potentially infectious material; and soiled utility rooms in the Urgent Care Center and a community living center contained housekeeping supplies.[48]

The OIG also reviewed selected Comprehensive Environment of Care performance metrics and found that despite VHA's expectation for staff to select one or more facility-specific environment of care trends and develop a plan to improve performance, they had not identified any trends to evaluate.[49]

The OIG recommends the Director ensures staff keep patient care areas safe and clean. The OIG also requests that the Director has staff conduct a risk assessment for community living center personal protective equipment locations to identify any needed improvements. The OIG recommends the Director ensures soiled utility rooms where biohazardous materials are stored display proper signage, have appropriate hand-washing supplies and equipment available, and do not contain housekeeping supplies. Further, the OIG recommends the Associate Director ensures staff identify one or more environment of care trends and establish a performance improvement plan, including outcome measures, to address them.

The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt

[47] 29 C.F.R. § 1910.1030 (2023).

[48] 29 C.F.R. § 1910.1030.

[49] Acting Deputy Assistant Under Secretary for Health for Operations, "Fiscal Year (FY) 2023 Comprehensive Environment of Care (CEOC) Guidance (VIEWS 9547420)," memorandum to Veterans Integrated Service Network (VISN) Directors, February 21, 2023.

action when needed.[50] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[51] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

In July 2023, VHA updated the *Communicating Test Results to Providers and Patients* directive and added a requirement for medical facilities to develop a local policy for communication of test results within 6 to 12 months.[52] The OIG found facility leaders had approved a local policy in March 2024 that identified requirements for abnormal and normal test results; established responsibilities for ordering and diagnostic providers; and included an expectation that leaders would create service-level workflows, which describe the team member roles in the communication process. However, through documentation received from the Acting Deputy Chief of Staff, the OIG learned that leaders had not yet implemented the workflows for all clinical services. The OIG did not make a recommendation regarding the local policy because VHA's deadline for completion had not yet passed at the time of the site visit.

The Informatics Supervisory Program Analyst explained that diagnostic providers communicated urgent, non-life-threatening test results to ordering providers through alert notifications in the patient's electronic health record. The program analyst acknowledged that providers experienced alert fatigue, which occurs when they become desensitized to numerous alerts, and stated it was one of the biggest challenges for medical facilities.[53] They also explained that VISN staff had created a dashboard to help facility staff view their total number of alerts to ensure they addressed them.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[54] The OIG evaluated previous action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

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

[51] Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, https://doi.org/10.1515/dx-2014-0035.

[52] VHA Directive 1088(1).

[53] Alerts are computerized "auditory or visual warnings to clinicians to prevent or act on unsafe situations." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

[54] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

At the time of the site visit, the OIG's recently published report on sterile processing deficiencies had nine open recommendations and facility staff stated they were working on improvement actions.[55] As noted in the Culture section, the OIG learned of an incident of improper processing of reusable medical equipment used in patient care while attending a daily leadership briefing.

In addition, the OIG reviewed audit results for communication of test results. The Assistant Chief of Quality Management explained that staff began auditing test results after the OIG reported two patient concerns related to delays in communication of laboratory and radiology test results to facility leaders in 2022. The assistant chief said the complaints prompted quality management staff to initiate two internal audits of the Primary Care Service in August 2022 and report findings at monthly Quality Executive Committee meetings. The assistant chief added that while quality management staff were conducting both internal audits, they identified the need to expand the review to include assessment of more providers and their communication of test results to patients.

Despite having these ongoing audits in place since late 2022, the OIG reviewed data during the site visit that showed a lack of improvements on timely communication of tests results to patients. Leaders reported taking several improvement actions beginning in mid-FY 2024; the OIG determined these actions were in the initial stages of implementation. For example, the Chief of Primary Care said primary care providers' performance pay plans and Ongoing Professional Practice Evaluations now included communication of test result documentation criteria; if providers do not meet the evaluation criteria, they will receive a for-cause Focused Professional Practice Evaluation.[56] However, the Acting Deputy Chief of Staff reported being unaware of the performance pay plan document. Additionally, a patient safety manager said the Acting Director initiated a wild card aggregate root cause analysis in

[55] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*.

[56] Leaders use the Ongoing Professional Practice Evaluation process to monitor a licensed independent health care practitioner's clinical performance. "Any findings of failure to meet expected benchmarks for successful clinical performance during the OPPE [Ongoing Professional Practice Evaluation] review may trigger a clinical performance concern resulting in further review and potential privileging actions." VHA Directive 1100.21(1), *Privileging,* March 2, 2023, amended April 26, 2023. "Performance Pay. A component of compensation paid to recognize the achievement of specific goals and performance objectives prescribed on a fiscal year basis by an appropriate management official. The purpose of performance pay is to improve the quality of care and health care outcomes through the achievement of specific goals and objectives related to the clinical, academic and research missions of VA." VA Handbook 5007, *Pay Administration*, October 16, 2020. "FPPE [Focused Professional Practice Evaluation] for Cause is a time-limited period during which the clinical service chief assesses the health care LIP's [licensed independent practitioner's]…privileges after a clinical concern has been triggered…It is not a restriction or limitation on the ability to practice independently, but rather an oversight process to be employed by the clinical service chief when there is a concern regarding a LIP's clinical competence to continue providing some aspect of patient care…Each FPPE for Cause is unique to the LIP and the identified clinical care concerns and is considered an Opportunity to Improve." VHA Directive 1100.21(1).

April 2024, which included 25 patient safety events related to communication of test results.[57] The OIG verified that facility staff had worked on the root cause analysis and established actions plans for improvement, which were in progress.

The OIG also reviewed reports from the Joint Patient Safety Reporting system and found instances of delayed patient notification of abnormal test results.[58] A patient safety manager described meeting with facility leaders daily to review adverse patient safety events. Additionally, this patient safety manager reported attending primary care monthly staff meetings to review adverse event reports, provide feedback, and encourage staff to continue reporting the events. The OIG noted that despite the audits discussed above and leaders' review of adverse events, leaders had not addressed communication of test result trends until recently.

The Acting Deputy Chief of Staff acknowledged leaders had failed to hold primary care leaders and providers accountable for not communicating test results in a timely manner. The ADPCS reported that the prior Director, Chief of Staff, and Deputy Chief of Staff were reassigned earlier in the year and explained there were issues with these leaders not holding their subordinates accountable. Additionally, the ADPCS reported bringing concerns to peers but not attempting to resolve them beyond expressing concerns. The Chief of Primary Care stated that managing the communication of test results was a challenging issue, and although ordering providers did not always document communication of test results in electronic health records, they did communicate the results to patients.

VHA expects providers to communicate test results to patients in a timely manner.[59] Timely communication of test results is essential to ensuring quality care, promoting patient engagement in the treatment process, and minimizing risks. The OIG found that facility leaders were aware of and acknowledged their lack of improvements for timely communication of test results to date. While recognizing the leaders' recent efforts to improve the communication of test results process, the OIG remains concerned about the leaders' ability to make and sustain improvements. In addition, during interviews, facility leaders acknowledged the internal audits were specific to primary care providers and did not include specialty care providers. The OIG is concerned that limiting audits to one service may decrease the opportunity for leaders to identify vulnerabilities with other ordering providers. The OIG recommends that facility leaders continue to develop and implement administrative processes to ensure ordering providers promptly communicate and document test results.

[57] A root cause analysis is a comprehensive and focused review used for "adverse events and close calls" requiring analysis. A wild card aggregate root cause analysis is a type of root cause analysis conducted from multiple patient safety events that do not meet the criteria for individual root cause analysis and may include frequent events with upward trends. VHA Directive 1050.01(1).

[58] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

[59] VHA Directive 1088(1).

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[60] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[61] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found a lack of continuous process improvement practices as previously noted. Additionally, when the OIG requested documents like current policies for selected topics, facility staff provided outdated VHA handbooks instead of the most current versions, and other information such as a primary care standard operating procedure that expired in 2021. The recently published hotline report on sterile processing services also identified facility staff using outdated standard operating procedures as a concern.[62]

The OIG discussed the outdated and expired documents during interviews with the Acting Deputy Chief of Staff and Chief of Primary Care. The Acting Deputy Chief of Staff acknowledged that many facility policies were expired and stated leaders were prioritizing updates. The OIG recommends that facility leaders ensure staff maintain and reference current VHA requirements and update facility-level policies and standard operating procedures to comply with them.

The OIG also found opportunities for staff to improve how they review and assess patient safety events. VHA requires patient safety managers to review patient safety events reported in the Joint Patient Safety Reporting system to assess the level of patient harm; assign actual and potential scores, known as safety assessment codes; and determine any further actions needed.[63] After reviewing adverse events from October 1, 2022, to April 25, 2024, the OIG identified multiple instances where the OIG would have assigned a higher potential safety assessment code score than a patient safety manager assigned.[64] During interviews, a patient safety manager, who had been in the position approximately four years, was unable to explain the process for scoring potential adverse events beyond referencing national guidelines. Additionally, the manager reported seeking guidance from the former Deputy Chief of Staff on how to score certain events,

[60] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

[61] VHA Directive 1050.01(1).

[62] VA OIG, *Sterile Processing Service Deficiencies and Leaders' Response at the Carl Vinson VA Medical Center in Dublin, Georgia*.

[63] VHA Directive 1050.01(1).

[64] "The potential score is what may have happened or what could have happened, based on the '*reasonable worst-case systems level scenario*'", while the actual score is what did occur. VHA National Center for Patient Safety, *Guidebook for Safety Assessment Code (SAC) Evaluation*, Version 11, March 2024.

stating physicians were the medical experts. However, per a VHA directive, the patient safety manager is responsible for scoring the events.[65]

Staff use the Joint Patient Safety Reporting system to generate reports to inform leaders on adverse event trends. According to a VHA directive, reporting adverse events is the "primary mechanism through which the NCPS [National Center for Patient Safety] learns about health care system vulnerabilities."[66] The OIG reviewed the three institutional disclosures for adverse events that staff said occurred in the past 12 months, two involving delayed communication of test results, treatment, or both.[67] The OIG was not able to find the events in the reporting system. Robust reporting of patient safety events helps leaders identify common themes to prioritize investigations, mitigate future occurrences, and promote a culture of zero harm. Further, data accuracy affects leaders' decisions about allocating resources for performance improvement activities. This failure and other examples described in this report highlight facility leaders' continued lack of appropriate oversight and improvement practices. Due to the levels of concerns with leadership accountability, the OIG's hotline team will investigate further.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[68] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[69] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational

[65] VHA Directive 1050.01(1).

[66] VHA Directive 1050.01(1).

[67] An institutional disclosure "is a formal process by which facility leaders, together with clinicians and other appropriate individuals, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in or is reasonably expected to result in death or serious injury." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[68] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

[69] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

staffing shortages.[70] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The facility had 41 primary care teams, and leaders planned to add 5 more teams in FY 2024 to staff the new clinic in Houston, Georgia. The existing teams had the following full-time equivalent vacancies: 4 registered nurses, 2 licensed practical nurses, and 15 medical support assistants. The ADPCS reported few challenges filling vacancies for nursing positions on primary care teams, explaining that Monday through Friday daytime hours, salary increases, and relocation incentives attracted applicants. In contrast, the Chief, Health Administrative Services said hiring and retaining medical support assistants was challenging because it was an entry-level position and locality pay for Dublin was lower than in other larger communities.[71] The Chief of Primary Care stated provider staffing was the best it had been over the past seven years, with all positions filled for the past eight months. The Acting Deputy Chief of Staff added that two local hospitals had recently changed ownership, causing some of the staff to start working at the facility.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[72] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[73]

The OIG determined that, on average, the primary care team panel capacity was 88.54 percent full for the last three quarters of FY 2023 and the first quarter of FY 2024. According to the Principal Facility Coordinator for the Patient Centered Management Module, the facility had two teams over VHA's 1,200 patient panel ceiling.[74] The Principal Facility Coordinator for the Patient Centered Management Module and the Chief of Primary Care explained they met weekly and as needed to review panel size data, discuss opportunities for improvement, and address any changes that may be needed, such as adjusting the panel size ceiling for providers, if needed. During an interview, primary care team members told the OIG that panel sizes were generally manageable with current staffing levels, but the time allotted for appointments was sometimes insufficient.

[70] VA OIG, *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*, Report No. 23-00659-186, August 22, 2023.

[71] The Chief, Health Administrative Services had been detailed to a different position just prior to the OIG site visit, and the OIG was not made aware until later in the week.

[72] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[73] VHA Directive 1406(1).

[74] VHA Directive 1406(1).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[75] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

During discussions with the OIG about staffing and training challenges, primary care staff identified inefficiencies with the care in the community consult process.[76] For example, primary care staff must ensure patients complete necessary tests before entering a consult, consults take time to enter and require renewal at predetermined time frames, approvals for consults can take an extended period of time, community care staff must obtain medical records from the consultant to include in the patient's record, and primary care staff must reenter the consult if not acted on promptly.

The Chief of Primary Care and the ADPCS attributed delays in consults being approved, in part, to a staffing shortage in the community care department, and the lack of availability for some specialists in the community. The Acting Deputy Chief of Staff explained that leaders monitor consults closely and attend daily leadership briefings, which resulted in some recent success in improving the consult process. The Acting Deputy Chief of Staff and the Chief of Primary Care said they work closely with the Community Care Manager to increase nursing staff in the community care department, which reduced consult approval delays.

Primary care staff shared that primary care nursing leaders provided a float nurse (nurse who is not assigned to a team and covers vacant positions) to assist with workflow. Float nurses are assigned to the team for the day and assist with caring for walk-in patients, taking vital signs, responding to electronic health record alerts, obtaining outside records for community care consults, and performing other daily tasks.

The ADPCS and the Chief of Primary Care had identified a general need to re-educate staff about the Patient Aligned Care Team model for primary care staffing and processes. Primary care nursing staff highlighted the addition of a new primary care educator and a new program, called the Ambulatory Care Employee Pathway Program. The program had improved training for new nurses; they learned the basics of primary care and how to use the electronic health record system before they began work. The ADPCS indicated the program was a nurse-driven initiative, and leaders planned to implement it for newly hired primary care staff.

[75] VHA Handbook 1101.10(2).

[76] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "VA Community Care," Department of Veterans Affairs, accessed November 21, 2024, https://www.va.gov/communitycare.

When asked about leadership support, primary care staff reported generally feeling supported by their immediate supervisors but perceived a lack of transparency and follow-up by facility senior leaders. As an example of leadership support, primary care leaders highlighted the planned opening of the new clinic in Houston, Georgia, which was scheduled for July 2024. When this clinic opens, the smaller Perry VA Clinic will close. The Perry clinic had three primary care teams, and the new Houston clinic will have eight, for a net increase of five teams. The Chief of Primary Care explained the location of the Houston clinic is in an area that should be easier for veterans to visit and has more space to allow for expansion.

The OIG also asked primary care leaders about transitioning from the facility-operated Telephone Advice Program to the VISN-operated Clinical Contact Center (which helps veterans with services like appointment scheduling, clinical triage, virtual care visits, and pharmacy services). The ADPCS stated the new system was confusing for facility staff and its implementation was challenging. For example, staffing shortages led to another VISN assisting the local VISN with staffing the contact center.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The facility's veteran enrollment rate decreased slightly from FY 2021 through FY 2023. The Acting Deputy Chief of Staff, ADPCS, and Chief of Primary Care said enrollment declined some due to the COVID-19 pandemic. The Acting Deputy Chief of Staff and the Chief of Primary Care also said they expected enrollment to increase when the new Houston clinic opened. Based on an interview with the Chief of Primary Care and wait time data, the OIG determined the PACT Act had not affected veterans' appointment wait times. In general, primary care staff reported no significant impact from the PACT Act implementation.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[77]

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[78] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[79]

The facility's HCHV5 measure trended upward from FY 2021 through FY 2023, exceeding the target the last year. The HCHV Coordinator attributed some of the increase to improved documentation in capturing patient encounters.

An HCHV outreach staff member reported identifying homeless veterans through the National Call Center for Homeless Veterans and the program's walk-in clinic, as well as through referrals from the facility's mental health, community living center, and acute care staff as well as county programs and shelters.[80] The staff member stated their program is generally the initial contact for veterans wishing to enroll. Program staff described a robust community outreach process and said HCHV5 data exceeded the target, which reflected their success with these efforts.

The HCHV Coordinator pointed out that staff require vehicles to perform outreach and identified an issue with four electric vehicles that facility leaders assigned to the program at the beginning of FY 2024. The coordinator said the facility's solar-powered charging stations did not work, so staff had to find alternative charging locations, which were rare in the predominately rural area. Staff traveled long distances without

A veteran who was struggling with substance abuse received assistance from the HCHV program to recoup many important documents lost in a fire. Program staff helped the veteran find housing and connect with a peer support specialist, who accompanied the veteran to Alcoholics Anonymous meetings. Over several years prior to death, the veteran gained access to necessary clinical care and reconciled with family, which may not have happened without support from VA programs.

Figure 11. *Example of veteran support.*
Source: OIG interview.

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

[78] VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022.

[79] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

[80] "VA Homeless Programs National Call Center for Homeless Veterans," Department of Veterans Affairs, accessed September 3, 2024, https://www.va.gov/HOMELESS/NationalCallCenter.asp.

the opportunity to recharge the vehicles, and charging could take several hours. Facility leaders recently replaced two of the electric vehicles because of these concerns.

The OIG recommends that facility leaders ensure homeless program staff have access to appropriate vehicles to conduct their work. The OIG also requests that facility leaders consider completing a risk assessment on the use of electric vehicles, including the availability of power sources and appropriate expected distances for staff travel.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[81] VHA captures data for these metrics by evaluating those veterans who are discharged from contracted residential services (community-based agencies that contract with local VA medical centers to provide short-term residential treatment) and low-demand safe haven programs (staffed transitional residencies for those chronically homeless with mental illness) to permanent housing.[82] This facility did not have data for the metrics because it did not have contracted residential housing or low-demand safe haven programs.

When asked about meeting veterans' needs, the HCHV outreach staff member stated program staff provide homeless veterans with the services needed to help them end homelessness. The outreach staff member explained that unstable housing was a suicide risk factor on the required suicide risk screening. Therefore, staff screened veterans during each encounter and provided appropriate support and referrals, if needed. The outreach staff member added that coordinating care for veterans experiencing homelessness is a continuous and ongoing process.

The HCHV Coordinator identified lack of affordable housing in the area as an ongoing issue. The coordinator reported that program staff work with local landlords, including holding a meet-and-greet event, to develop relationships. The coordinator added that helping veterans establish income sources through benefits and employment services represented veteran and program success.

[81] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[82] "HCHV CRS [Contracted Residential Services] programs target and prioritize Veterans transitioning from literal street homelessness…[who] require safe and stable living." Veterans can stay in Contracted Residential Services usually from 30 to 90 days. One model of Contract Emergency Residential Services programs is Low Demand Safe Havens where a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[83] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[84]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[85] The facility program exceeded the FY 2023 performance measure target. The Veterans Justice Program Coordinator described identifying veterans for program enrollment through referrals from the local court, jail, and legal assistance staff.

The coordinator stated the program has outreach staff but no position specific for a staff member to help incarcerated veterans reintegrate into the community after their release. The coordinator reported requesting to fill that role but had not received approval.

Meeting Veteran Needs

The Veterans Justice Program Coordinator explained that, after receiving a referral, staff reach out to the veteran via phone or in person and conduct an assessment. Staff assess factors such as previous incarcerations and other legal matters, medical concerns, mental health, housing, income, and employment.

The coordinator reported developing and maintaining relationships with community and state agencies to help with resources like housing and legal services. In addition to referring veterans to the facility's Housing and Urban Development–Veterans Affairs Supportive Housing program for permanent housing, veterans justice outreach staff said they look forward to working with staff from the National Alliance on Mental Illness of Central Georgia on that

A Coast Guard veteran experienced homelessness after a substance use disorder triggered events leading to involvement with the court system. After the veteran received treatment in the domiciliary and completed court requirements, staff referred the veteran to a peer support program staffed by individuals who have personal experience with recovery from mental health conditions. The veteran later found employment in the peer support program.

Figure 12. *Veterans Justice Program success story.*
Source: OIG interviews.

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

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

[85] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

organization's new project that will build several tiny houses and accept veteran referrals.

Housing and Urban Development–Veterans Affairs Supportive Housing

Housing and Urban Development–Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[86] The program uses the housing first approach, which prioritizes rapid acceptance to a housing program followed by individualized services, including healthcare and employment assistance, necessary to maintain housing.[87]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[88] The facility's program did not meet the target from January 2021 through June 2023, but the program coordinator attributed these failures to a clerical error that staff identified and corrected in September 2023. For FY 2023 quarter four and FY 2024, year to date, the facility had met the target.

The program coordinator explained that staff identify veterans through outreach efforts and referrals from facility staff. Program staff provide program information to community partners such as shelters, warming centers, libraries, and community centers, where staff might encounter homeless veterans. The coordinator further detailed how staff forged strategic partnerships with community landlords, churches, veterans' organizations, and mental health programs to find opportunities for housing services. Additionally, to increase the program's visibility and public presence, staff took an active role in the local homeless coalition and instituted a monthly

A homeless veteran referred to the Housing and Urban Development-Veterans Affairs Supportive Housing program found housing, connected with employment services, began work at a VHA facility in the housekeeping department, and graduated from the program within nine months. The veteran had steady employment and was looking forward to buying a home.

Figure 13. *Program success story. Source: OIG interviews.*

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

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

[88] VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

meeting where community partners can present on relevant topics for meeting veterans' needs.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[89] The program met the target in quarters two through four in FY 2021, but had not met it since. Staff stated that one possible barrier to meeting the target was because information used for this measure was reliant on veterans' self-reporting their incomes to facility staff, and they may not always report them. Staff added that once veterans' income reached a certain threshold, they may become ineligible for program housing vouchers, but staff can provide case management services for an additional six months.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, 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.

[89] VHA sets the VASH3 target at the national level. For FY 2023, the target was 50 percent or above. VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

OIG Recommendations and VA Response

Finding: The OIG observed multiple inaccurate wayfinding signs throughout the facility. For example, several signs indicated the emergency department was straight ahead, but the facility no longer had an emergency department.

Recommendation 1

The OIG recommends that facility leaders review and correct any outdated navigational signage.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

A Non-Recurring Maintenance (NRM) Project Application was submitted in 2019 to update the exterior signage for the facility. This project will replace outdated and inaccurate exterior roadway and directional signage through the campus. The NRM application was approved but has not been funded to date. Project funding is dependent on the scoring conducted by the Network 7 Capital Asset Management (CAM) office and the budgets which are allocated to those programs. This project has not ranked high enough to fall within the annual NRM funding threshold since the original Strategic Capital Investment Plan (SCIP).

However, temporary corrections to inaccurate signage have been made. Exterior signage at the entrance of the facility off Highway 80 has been covered with printed vinyl banners. Inside the facility, signage has been purchased and hung in the hallways indicating directions to the most common outpatient areas such as Primary Care, Pharmacy, and Surgical Clinic. The Urgent Care now has a sign posted in the waiting room indicating it is the Urgent Care Center.

OIG Comments

The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

Finding: The facility had two staff identified as toxic exposure screening navigators, but they had limited responsibility in the role and navigator functions were spread out across multiple staff members. In addition, staff had not completed 457 toxic exposure screenings.

Recommendation 2

The OIG recommends facility leaders define and assign roles and responsibilities to toxic exposure screening navigators and ensure program oversight.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The Chief of Primary Care has identified the PACT Act Toxic Exposure Screening (TES) staff member in Primary Care that provides oversight of the navigators. The Chief of Primary Care will identify two navigators. Primary Care leadership will outline the roles and responsibilities for the toxic exposure screening program navigators per the PACT Act Toxic Exposure Screening (TES) SharePoint guidance and issue it to the TES navigators.

The navigators will be listed on the PACT Act Toxic Exposure Screening (TES) SharePoint page in the TES Navigators. The PACT Act Toxic Exposure Screening Lead will report program oversight to Quality Executive Council monthly as a standing agenda item on TES measures. Compliance with the oversight reporting will be met after six (6) consecutive months of TES reports to Quality Executive Council have been captured.

Finding: The OIG observed multiple cracks in hallway floor joints, unpainted and unrepaired holes in the walls, and dusty and dirty areas.

Recommendation 3

The OIG recommends the Director ensures staff keep patient care areas safe and clean.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

Environmental Management Service (EMS) supervisors and Accreditation Specialist will conduct inspections with a minimum of one patient care area per month. Inspections will include identification of dust and dirt, and findings will be remediated at the time of inspection and/or work orders placed for any identified maintenance needs. The denominator will be the number of inspection concerns identified in patient care areas per month. The numerator will be the number of identified inspection concerns remediated within two weeks of identification per month. A minimum of 90 percent compliance will be achieved for six consecutive months. EMS leadership will report data to the Quality Executive Council monthly, which is co-chaired by the Medical Center Director.

Finding: The Urgent Care Center's soiled utility room did not have a nearby sink or hand sanitizer in the area; the medical/surgical ward's soiled utility room lacked a biohazard sign to warn staff of potentially infectious material; and two soiled utility rooms contained housekeeping supplies.

Recommendation 4

The OIG recommends the Director ensures biohazard storage areas display proper signage, have appropriate hand-washing supplies and equipment available, and do not contain housekeeping supplies.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The proper signage for the medical/surgical ward's soiled utility room was corrected at the time of survey. Hand sanitizers were placed near the soiled utility room in the Urgent Care Center. All soiled utility rooms were inspected, and any housekeeping supplies removed at the time of inspection.

The Quality Accreditation Specialists will audit the placement of biohazard signs and the absence of housekeeping supplies for all the facility's soiled utility rooms and report the audit to the Quality Executive Council monthly, co-chaired by the Medical Center Director. The denominator is the number of soiled utility rooms, and the numerator is the soiled utility rooms

in compliance. Audits will continue until six (6) consecutive months of 90% compliance is achieved.

Finding: Facility staff had not identified one or more facility-specific environment of care trends to evaluate and develop an improvement plan to address them.

Recommendation 5

The OIG recommends the Associate Director ensures staff identify one or more facility environment of care trends and establish a performance improvement plan, including outcome measures, to address them.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The current Environment of Care Committee (EOCC) charter will be reviewed and updated to reflect compliance with VHA Directive 1608(1) Comprehensive Environment of Care Program. The EOCC committee is a multidisciplinary group that will review the most reported issues identified in weekly environment of care rounds. A continuous performance improvement plan, including outcome measures, will be a standing agenda item for the committee. Compliance will be met after six (6) consecutive months of minutes in the Environment of Care Committee show discussion of environment of care trends as a standing agenda item.

Finding: Despite auditing and awareness of delays in communicating test results to patients, leaders had not implemented process improvements in a timely manner.

Recommendation 6

The OIG recommends that facility leaders continue to develop and implement administrative processes to ensure ordering providers promptly communicate and document test results.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The facility is collaborating with VISN 7 as they are working to obtain a third-party vendor that offers solutions for lab/radiology results that will automatically generate and create a letter for the primary care provider to review and sign. Centralized printing has been implemented as of May 29, 2024. A random monthly chart audit of fifty (50) Primary Care laboratory results will be completed by a Quality Management Coordinator until compliance of 90% or greater is reached for six consecutive months to ensure compliance with VHA Directive 1088(1). The results of the audit will be reported monthly in the Quality Executive Council, which is co-chaired by the Medical Center Director.

Finding: Facility staff provided outdated policies to the OIG. The OIG's recently published hotline report on sterile processing deficiencies included a similar finding.

Recommendation 7

The OIG recommends that facility leaders ensure staff maintain and reference current VHA requirements and update facility-level policies and standard operating procedures to comply with them.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

Local policies are tracked and maintained in Quality Management. A Quality Management Program Analyst tracks all local policies and standard operating procedures for the facility including the expiration dates. Notifications are sent to the responsible service lines on approaching due dates. The tracking and trending of policies and SOPs pending expiration dates are reported out quarterly in Quality Executive Council. Compliance will be achieved when six (6) consecutive months of ninety (90) percent compliance is achieved of non-expired policies and SOPs for the Dublin Medical Facility.

Policies are in the Medical Center SharePoint page for all employee access. Education has been provided to all staff regarding how to look up local and national policies in the supervisor townhall, all employee townhall, morning report, and in the *Dublin Daily Update*.

Finding: Facility staff assigned electric vehicles to the homeless program; however, the facility's solar-powered charging stations did not work, leaving the staff to find locations outside the facility to charge the vehicles, which were limited in the predominately rural area. Also, charging the vehicles could take several hours.

Recommendation 8

The OIG recommends facility leaders ensure homeless program staff have access to appropriate vehicles to conduct their work.

_X_ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The Medical Center Director evaluated this recommendation and found no additional reasons for noncompliance.

The homeless program staff were surveyed about the type of vehicle (gasoline or electric) that would be appropriate to use for the area they serve patients. Vehicles were issued to the homeless staff per their request. Gasoline vehicles were provided to the staff who requested them. There are eleven total staff for the homeless program who required vehicles at the Carl Vinson VA Medical Center. Ten of the eleven staff have gasoline vehicles and one has an electric vehicle. The staff who has the electric vehicle works out of the Macon Community Based Outpatient Clinic, the closest Tesla charging station is within eight miles of the where the vehicle is parked.

Engineering will generate a vehicle utilization report for all the fleet cars used for the facility. The vehicle utilization report will be sent to the homeless program coordinator to review with staff about appropriate vehicle type and usage. The vehicle utilization report will be reviewed in monthly staff meetings as a standing agenda item for sustainability. Compliance will be met after six (6) consecutive months of vehicle utilization reports are discussed in the Homeless Program Staff meetings.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from April 16 through 18, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

[2] The OIG sent questionnaires to multiple VSO representatives but received a response from only one VSO: United Military Care.

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

[4] 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] 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.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

Category	Metric	Metric Definition
Population	Total Population	Population estimates are from the US Census Bureau and include the calculated number of people living in an area as of July 1.
	Veteran Population	2018 through 2022 veteran population estimates are from the Veteran Population Projection Model 2018.
	Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Part 1 provides point-in-time (PIT) estimates, offering a snapshot of homelessness—both sheltered and unsheltered—on a single night.
Education	Completed High School	Persons aged 25 years or more with a high school diploma or more, and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people whose highest degree was a high school diploma or its equivalent. People who reported completing the 12th grade but not receiving a diploma are not included.
	Some College	Persons aged 25 years or more with a high school diploma or more and with four years of college or more are from the US Census Bureau's American Community Survey Summary File. High School Graduated or More fields include people who attended college but did not receive a degree, and people who received an associate's, bachelor's, master's, or professional or doctorate degree.
Unemployment Rate	Unemployed Rate 16+	Labor force data are from the Bureau of Labor Statistics' Local Area Unemployment Statistics File for each respective year. Data are for persons 16 years and older, and include the following: Civilian Labor Force, Number Employed, Number Unemployed, and Unemployment Rate. Unemployment rate is the ratio of unemployed to the civilian labor force.
	Veteran Unemployed in Civilian Work Force	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. Veterans are men and women who have served in the US Merchant Marines during World War II; or who have served (even for a short time), but are not currently serving, on active duty in the US Army, Navy, Air Force, Marine Corps, or Coast Guard. People who served in the National Guard or Reserves are classified as veterans only if they were ever called or ordered to active duty, not counting the 4-6 months for initial training or yearly summer camps.

Category	Metric	Metric Definition
Median Income	Median Income	The estimates of median household income are from the US Census Bureau's Small Area Income Poverty Estimates files for the respective years.
Violent Crime	Reported Offenses per 100,000	Violent crime is the number of violent crimes reported per 100,000 population. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.
Substance Use	Driving Deaths Involving Alcohol	Alcohol-impaired driving deaths directly measures the relationship between alcohol and motor vehicle crash deaths.
	Excessive Drinking	Excessive drinking is a risk factor for several adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.
	Drug Overdose Deaths	Causes of death for data presented in this report were coded according to International Classification of Diseases (ICD) guidelines described in annual issues of Part 2a of the National Center for Health Statistics Instruction Manual (2). Drug overdose deaths are identified using underlying cause-of-death codes from the Tenth Revision of ICD (ICD–10): X40–X44 (unintentional), X60–X64 (suicide), X85 (homicide), and Y10–Y14 (undetermined).
Access to Health Care	Transportation	Employment and labor force data are from the US Census Bureau's American Community Survey Summary File. People who used different means of transportation on different days of the week were asked to specify the one they used most often or for the longest distance.
	Telehealth	The annual cumulative number of unique patients who have received telehealth services, including Home Telehealth, Clinical Video Telehealth, Store-and-Forward Telehealth and Remote Patient Monitoring - patient generated.
	< 65 without Health Insurance	Estimates of persons with and without health insurance, and percent without health insurance by age and gender data are from the US Census Bureau's Small Area Health Insurance Estimates file.
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: Additional Facility Photos

Figure C.1. *Entrance sign from Veterans Boulevard.*
Source: Photo taken by OIG inspector.

Figure C.2. *Map of the Carl Vinson VA Medical Center.*
Source: Facility Staff.

Figure C.3. *Navigational sign.*
Source: Photo taken by OIG inspector.

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 3, 2025

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia

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

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

1. I have completed a full review of the Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia draft report and concur with the findings.
2. I concur with the recommendations and action plan submitted by the VA Dublin Healthcare System in Georgia.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

David M. Walker, MD, MBA, FACHE

Appendix E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 10, 2024

From: Interim Executive Director, VA Dublin Healthcare System (557)

Subj: Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia

To: Director, VA Southeast Network (10N7)

1. I have had the opportunity to review the Healthcare Facility Inspection of the VA Dublin Healthcare System in Georgia. I concur with the recommendations and considerations in the report.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans. The Carl Vinson VA Medical Center remains committed to ensuring our Veterans receive health care of the highest quality.

(Original signed by:)

Chandra Miller, MSN, RN, CNL
Interim Executive Director
Carl Vinson VA Health Care System

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