US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia

Healthcare Facility Inspection	24-00606-137	June 12, 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 Atlanta Healthcare System (facility) from June 25 through 27, 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. During interviews, facility leaders stated infrastructure issues that affect patient care were a system shock. Leaders described multiple issues, such as water line breaks that flooded the intensive care unit and radiology clinic and nonfunctioning air conditioning units. Leaders said plumbing issues and the lack of air conditioning caused staff to reschedule patients' appointments or convert them to telehealth. Although the Director reported working with VHA to improve the infrastructure, the OIG recommends leaders develop a plan to resolve the issues that affect patient care.

The facility leaders told the OIG that turnover in key leadership positions was another system shock. At the time of the OIG site visit, leaders informed the OIG of the appointment of a new Director and the return of the Associate Director for Nursing Patient Care Services after a temporary assignment.

[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.

Responses to an OIG questionnaire indicated that some staff found leaders' communication to be unclear and infrequent, although All Employee Survey results demonstrated improvement in senior leader communication and information sharing between fiscal years 2022 and 2023.[2] Leaders acknowledged that communication to frontline staff did not always occur, but they shared examples of information boards throughout the facility, daily emails to staff, and town hall meetings every two months as ways they improved communication.

While the All Employee Survey best places to work score was higher in fiscal year 2023 than in fiscal years 2021 or 2022, the OIG questionnaire indicated many respondents felt the culture of the facility was not moving in the right direction, and stress was a reason they considered resigning.[3] The Associate Director for Nursing Patient Care Services added that staff have access to resources to manage stress, such as meditation, chair yoga, and short-term counseling.

Patient advocates and veterans service organization representatives who responded to the OIG questionnaire indicated that veterans' top concern was the phone system; specifically, the inability to leave messages for clinic staff, extended hold times, frequent disconnections, and the lack of direct phone lines to clinics like primary care.[4] Leaders said they were aware of the phone issues and attempted to address them over a year prior to the OIG's visit; however, the issues persist and received media attention. The OIG recommends facility leaders develop and implement a plan to resolve veterans' unanswered phone calls and their inability to reach staff.

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 recurring issues.

After arriving at the facility, the OIG found emergency call boxes in the parking garage were not working and had signs instructing veterans to call VA police for assistance. The OIG recommends leaders replace the emergency call boxes.

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[2] 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.

[3] Best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

[4] 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/. Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

The main entrance appeared clean and welcoming. The OIG also inspected the Emergency Department, a primary care clinic, and a critical care unit and found the areas to also be clean and safe overall. However, the OIG found outdated sterile medical supplies and clean and dirty equipment stored together in a clean utility room. Staff promptly resolved these issues, and therefore, the OIG did not make a recommendation.

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 found facility leaders and staff followed an established process for communicating test results, but several policies and memorandums related to test result communication were outdated. Although facility leaders said they were actively updating them, the OIG issued a recommendation.

The OIG also learned that leaders had not completed institutional disclosures for two patient safety events that occurred in fall 2022, related to communication of abnormal test results.[5] Executive leaders signed memorandums in spring 2023 agreeing to conduct institutional disclosures for the events. However, after the OIG requested related documentation, facility leaders found they had not completed them. The Risk Manager, who contacts the family to schedule the disclosure appointment, attributed the missed disclosures to vacant risk manager positions. The OIG recommends the Chief of Staff conducts institutional disclosures for applicable adverse events.

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.[6]

At the time of the inspection, the OIG found the primary care clinics had over 200 vacancies for providers, registered nurses, licensed practical nurses, medical support assistants, and pharmacists. The Chief Nurse for Primary Care said they had selected candidates for most of the vacant nursing positions. A primary care leader and staff added that the time needed to bring new

[5] An institutional disclosure is a formal process by which VA leaders and clinicians inform patients and families that an adverse event has occurred which resulted in, or may result in, serious injury or death. During disclosure, patient recourse and rights are discussed. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

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

employees onboard was the biggest issue with staffing, and the Deputy Director said it took approximately 300 days to hire employees.

Primary care leaders and staff also said vacancies increased primary care teams' workload and panel sizes (number of patients assigned to a care team). A primary care physician raised concerns about the workload leading to patient safety issues, such as missed lab results, incorrect prescription orders, or unanswered clinical messages. Primary care leaders discussed strategies, such as hiring temporary providers, moving providers from one panel to another, and offering veterans appointments with other primary care teams, to help manage workload and panel sizes. However, because leaders were unable to maintain the panels at reasonable sizes, the OIG made a recommendation.

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 to assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans program, which is an umbrella for multiple programs, did not meet the targets for the number of unsheltered veterans who received a program intake assessment in fiscal years 2022 or 2023. Despite missing the targets, staff continued to conduct outreach, and program leaders said staff participated in the annual point-in-time count and found it useful to identify unsheltered veterans to enroll.[7]

The Housing and Urban Development–Veterans Affairs Supportive Housing program staff informed the OIG that limited housing availability and delays in veterans obtaining necessary documents were challenges to acquiring housing. Program staff addressed these barriers by working closely with community partners.

Staff also discussed delays in veterans receiving medical clearance for employment through the Compensated Work Therapy program.[8] Staff said the loss of a medical provider who expedited the clearances caused them to refer veterans to primary care providers, which could delay the clearance up to two months. The OIG was concerned about these delays and made one recommendation.

[7] 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.

[8] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment support to Veterans and employers." "Veterans Health Administration, Compensated Work Therapy," Department of Veterans Affairs, accessed July 11, 2024, https://www.va.gov/health/cwt/.

What the OIG Recommended

The OIG made seven recommendations for improvement.

1. Facility leaders develop and implement a plan to resolve infrastructure issues that affect patient care.
2. Facility leaders develop and implement a plan to resolve veterans' unanswered phone calls and inability to reach staff.
3. Facility leaders replace the emergency call boxes in the parking garage to ensure they are active and functioning.
4. Facility leaders update local policies and memorandums related to communication of test results.
5. The Director ensures the Chief of Staff conducts institutional disclosures for applicable adverse events.
6. Facility leaders take additional actions to obtain manageable panel sizes per VHA guidelines and ensure patients have access to high-quality care.
7. Facility leaders evaluate and improve processes for medical clearance of veterans who participate in the Compensated Work Therapy program.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendations and provided acceptable improvement plans (see appendixes C and D 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 5 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

ADNPCS	Associate Director for Nursing 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 Atlanta Healthcare System
Decatur, Georgia
Level 1a-High Complexity
DeKalb County
Hospital Referral Region: Atlanta

Description of Community

POPULATION

Female **3,921,370**	Male **3,677,183**
Veteran Female **54,314**	Veteran Male **365,147**

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

MEDIAN INCOME

$58,796

EDUCATION

86% Completed High School
55% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **262**

SUBSTANCE USE

20.0% Driving Deaths Involving Alcohol
18.0% Excessive Drinking
1,691 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	2,701,459
Carpool	324,570
Work at Home	323,948
Public Transportation	84,201
Other Means	62,930
Walk to Work	46,830

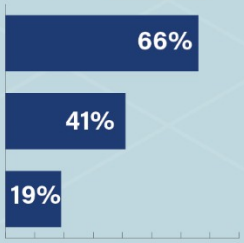
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**25.5 Minutes, 22.5 Miles**
Specialty Care	**68 Minutes, 65 Miles**
Tertiary Care	**70 Minutes, 66 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **82,296**



Health of the Veteran Population

681 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

43,015

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.94 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

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

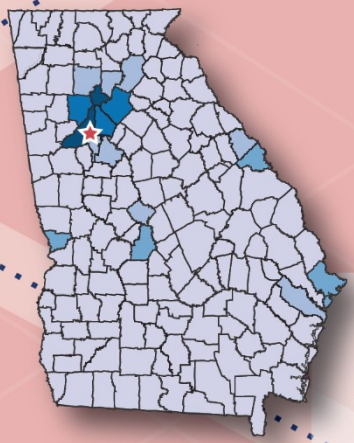
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	151K
Unique Patients VA Care	143K
Unique Patients Non-VA Care	56K

COMMUNITY CARE COSTS

Unique Patient	$19,283
Outpatient Visit	$300
Line Item	$462
Bed Day of Care	$257



STAFF RETENTION

Onboard Employees Stay <1 Yr	8.95%
Facility Total Loss Rate	11.06%
Facility Retire Rate	2.60%
Facility Quit Rate	7.78%
Facility Termination Rate	0.42%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.02% 1.51%% 3.00% 4.49% 5.98% 7.42%

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.

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]

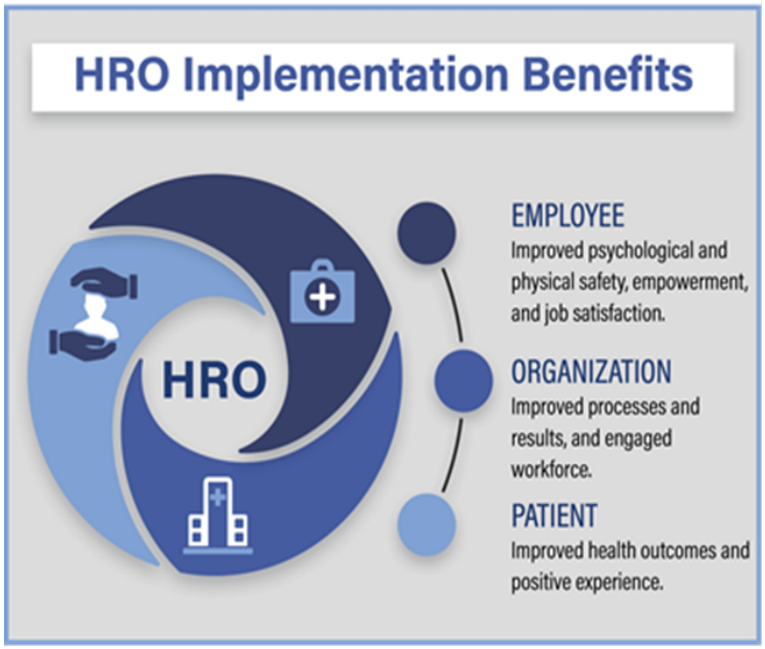


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 prioritize HRO principles increase employee engagement and improve

[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.

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. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

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.

A staff member shared that construction of the VA Atlanta Healthcare System (facility) began in January 1964, and patients began receiving care on June 21, 1966. At the time of the inspection, the executive leaders consisted of the Executive Director (Director), Deputy Executive Director (Deputy Director), Chief of Staff, Associate Director for Nursing Patient Care Services (ADNPCS), Associate Director for Infrastructure, Associate Director for Outlying Sites, and Assistant Director. The facility had 306 operating beds (192 hospital, 42 community living center, 61 domiciliary, and 11 compensated work therapy-transitional residence beds), and a fiscal year (FY) 2023 medical care budget of approximately $1.5 billion.[13]

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."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] 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).[16]

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed January 17, 2025, https://www.va.gov/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. "The Compensated Work Therapy-Transitional Residence (CWT-TR) programs are designed for Veterans whose rehabilitative focus is based on CWT and transitioning from this level of care to successful independent community living." VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, July 15, 2019.

[14] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

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

[16] 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.[17] 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.[18] 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. *The aging infrastructure's impact on staff. Source: OIG interview.*

Leaders described various infrastructure issues, including water line breaks that caused flooding in the intensive care unit and radiology clinic and inoperable air conditioning units, as a system shock. Leaders said they experience inoperable air conditioning or plumbing issues daily, causing staff to reschedule patients' appointments or convert them to telehealth. The Chief of Staff stated the infrastructure issues make providing quality care challenging, but due to the frequency of these issues, staff had learned to adapt to ensure patient safety and continuity of operations. Additionally, the Director emphasized working with VHA to explore improvements to the facility infrastructure. The OIG recommends facility leaders develop and implement a plan to resolve infrastructure issues that affect patient care.

Facility leaders also identified turnover in leadership positions as a system shock. The leaders discussed their tenure, explaining the ADNPCS assumed the role in 2019 but was detailed (temporarily assigned) to another position for several months from 2023 to 2024; the Deputy Director and Chief of Staff were appointed in 2022; the Assistant Director had been in the role since May 2024; the Director was appointed in June 2024; and the other two Associate Directors were in an acting capacity.

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

[18] 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*.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[19] 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.[20] 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."[21] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[22]

Figure 5. *Leader communication with employees.*
Source: OIG questionnaire and interviews with facility leaders.

All Employee Survey results showed improvement in senior leader communication and information sharing scores between FYs 2022 and 2023.[23] However, OIG questionnaire responses indicated that some employees found leader communications to be of no use, unclear, and infrequent.

In interviews, leaders said that in the past, messages did not always reach frontline employees, but they believed communication had improved compared to the previous year. Leaders added they implemented several strategies to improve communication, including daily huddles and use

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

[20] 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*.

[21] 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.

[22] 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.

[23] Senior leader goal communication measures leaders' communication of the organization's goals and senior leader information sharing measures how satisfied employees are with the information received from leaders. "2024 VA All Employee Survey (AES), Questions by Organizational Health Framework," VHA National Center for Organization Development.

of huddle boards throughout the facility, daily emails to all employees, and employee town hall meetings held every two months.[24]

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26]

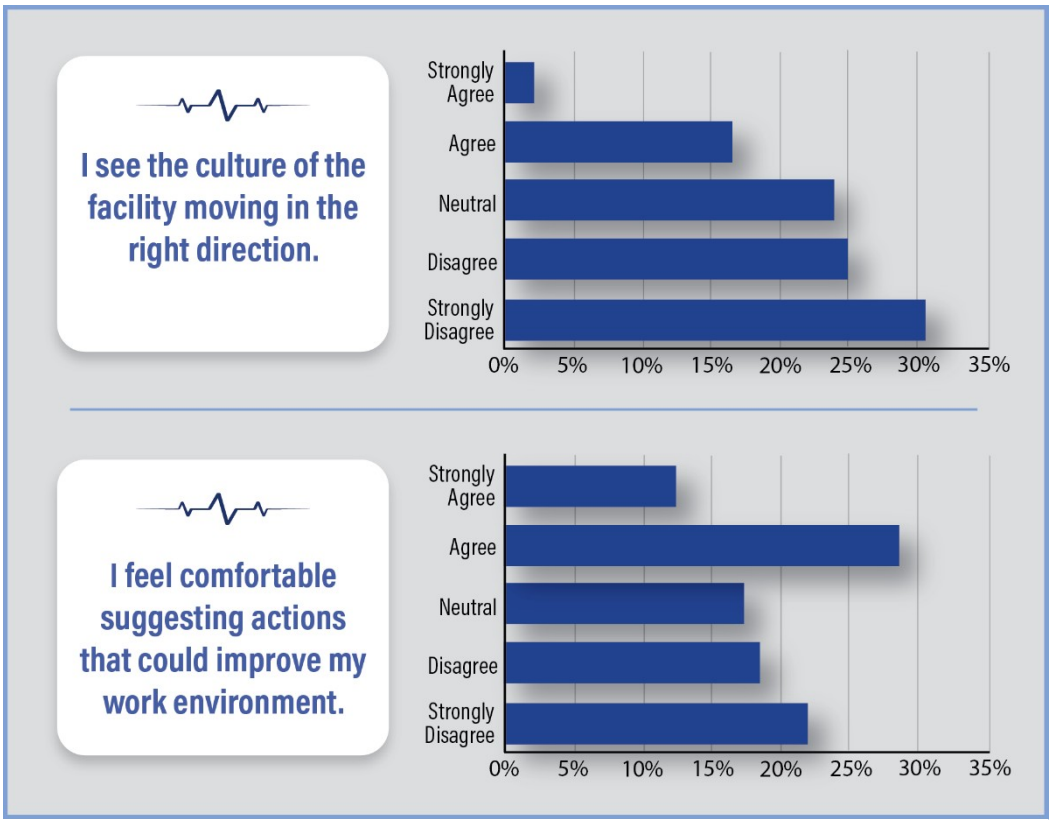


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

[24] A huddle is a brief meeting between a team and relevant discipline-specific team members to share information about patient care. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 24, 2024. A huddle board is a visual management tool used to enhance communication and collaboration among healthcare teams by displaying key patient safety information, facilitating daily discussions, and tracking improvement initiatives. "The Patient Safety Huddle Board: A New Tool for an Old-Fashioned Business Practice," Department of Veterans Affairs, accessed February 26, 2025, https://www.patientsafety.va.gov.

[25] "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.

[26] 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.

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. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

The facility's All Employee Survey's best places to work score decreased in FY 2022, but the FY 2023 score exceeded FYs 2021 and 2022.[27] The Chief of Staff and ADNPCS explained that the lower FY 2022 score could be related to the repeal of telework for some employees who did not want to return to the office.

Many employees indicated the facility's culture was not moving in the right direction (see figure 6). Employees also identified bad leadership, feeling disrespected at work, a lack of advancement opportunities, and stress and burnout as reasons they considered leaving the facility. The ADNPCS explained that employees have access to well-being resources, including meditation, chair yoga, and short-term counseling to help manage stress.

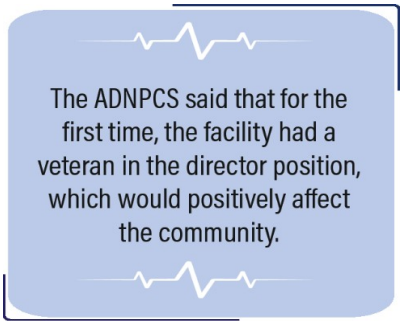


Figure 7. *The ADNPCS's comment regarding the facility Director. Source: OIG interview.*

Employees were divided on whether they were comfortable suggesting actions to improve the work environment (see figure 6). However, All Employee Survey psychological safety scores increased over the three years prior to the OIG's site visit. Additionally, most OIG questionnaire respondents indicated they felt comfortable reporting patient safety concerns.

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.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Patient advocate and VSO questionnaire responses conveyed that veterans' primary concerns were related to the phone system, including the lack of available options to leave messages for clinic staff, extended hold times, frequent disconnections, and the absence of direct phone lines

[27] Best places to work "is a summary measure of the group's satisfaction with the job, organization, and likelihood to recommend VA as a good place to work." "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

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

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

to clinics, such as primary care. The Deputy Director told the OIG that leaders were aware of the phone system issues and had started to address them by assigning staff to manually check and restore inactive phone lines over a year prior to the OIG visit. However, the OIG noted that local media had published veterans' criticisms about the phone system in July 2021, and a patient advocate responded in an OIG questionnaire that staff not answering phones had been a common concern for veterans over the previous five years, indicating the problem had been long-standing.[30] The OIG recommends facility leaders develop and implement a plan to resolve veterans' unanswered phone calls and inability to reach staff.

Patient advocates identified staff's cancellation of appointments without notifying veterans as another concern. The Deputy Director told the OIG that leaders were not aware of staff canceling appointments and not rescheduling them, but would address the issue immediately, if needed.

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.[31] 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 8. *Facility photo.*
Source: "VA Atlanta Health Care," Department of Veterans Affairs, accessed June 24, 2024, https://www.va.gov/atlanta-health-care/.

[30] Justin Gray, "Veterans Having a Hard Time Reaching the VA Medical Center Because of New Phone System," *95.5WSB*, July 7, 2021, https://www.wsbradio.com/news.

[31] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[32] 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.[33]

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.

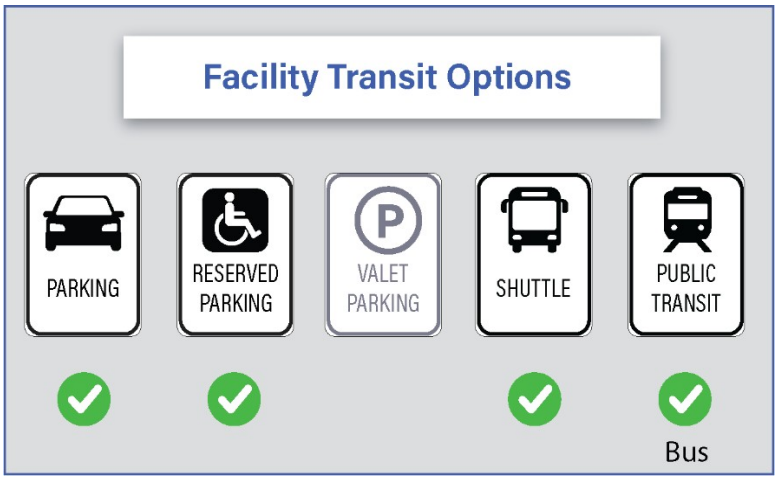


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and interviews.

The OIG used the link located on the facility's website to navigate to the main entrance, then used the facility's signage to locate the parking garage. The OIG noted that emergency call boxes in the parking garage were out of order, with signs instructing veterans to call VA police if they need assistance. Staff provided the OIG with documentation of a price quote to replace them. The OIG recommends facility leaders replace the emergency call boxes to ensure they are active and functioning.

[32] 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.

[33] 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.

Main Entrance

Figure 10. *Facility front entrance.*
Source: Photo taken by OIG inspector.

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.[34]

The OIG found the main entrance to be easily identifiable from signage. Additionally, there was a canopy between the parking garage and entrance, as well as covered areas for cars and shuttles to pick up and drop off veterans. The OIG entered through the main entrance and observed wheelchairs available for use. Directly inside was an information desk with greeters available to assist. The area also had natural lighting and seating for veterans. The OIG's overall impression was the entrance had a clean and welcoming atmosphere.

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.[35]

At a kiosk in the parking garage, the OIG was able to print turn-by-turn instructions to specific locations throughout the facility. Inside the facility, multiple cues communicated locations of services, including large print and color-coded maps, signage in hallways and intersections, and more kiosks with printable instructions. Additionally, a wayfinding smartphone application was available to further assist veterans in navigating the facility.

[34] 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*.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] The OIG observed braille signage in elevators and detectable warnings leading to the main entrance, while the wayfinding smartphone application offered amplified audible turn-by-turn directions to selected clinics.[37] The greeters at the information desk informed the OIG they had received training for guiding visually impaired veterans to their destinations.

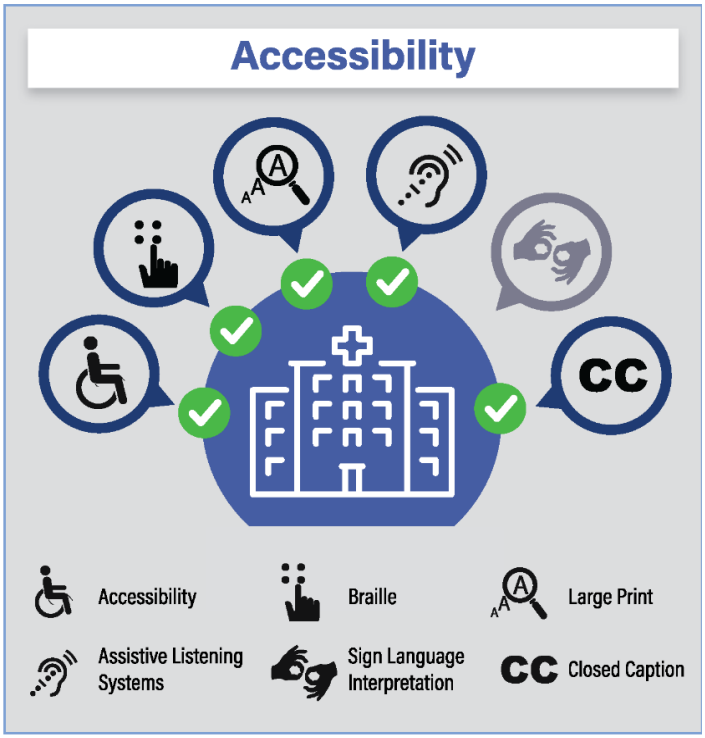


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG interviews and review of documents.

Toxic Exposure Screening Navigators

VA recommends that each facility 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.[38]

The facility had four toxic exposure screening navigators, including three social workers and one nurse practitioner. The navigators reported no wait time for initial screenings. At the time of the inspection, the Quality Accreditation Specialist said the navigators had conducted 57 outreach events, which included offering information and on-site screenings. Additionally, the OIG found toxic exposure screening handouts and sufficient resources available to support veterans at the facility's information desk.

[36] 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.

[37] "Detectable warnings are a distinctive surface pattern of domes detectable by cane or underfoot that alert people with vision impairments of their approach to street crossings." Access Board, *(Proposed) Public Right-of-Way Accessibility Guidelines, Additional Resources*, March 2014, https://www.access-board.gov/update.html.

[38] 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.[39] 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 reviewed environment of care data involving staff closing deficiencies within 14 days of identifying them, as required by VHA, and found they did not meet the target in quarter two of FY 2024 and were not expected to meet it in quarter three.[40] During an interview, staff said leaders added an additional level of oversight to ensure staff monitored open deficiencies. Since leaders were acting to ensure accountability and monitor outstanding deficiencies, the OIG did not make a recommendation.

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 three clinical areas (the Emergency Department, a primary care clinic, and a critical care unit) and found them to be generally clean and safe. However, the OIG discovered infection control concerns in two clinical areas: outdated sterile commercial medical supplies and dirty and clean equipment stored together in a clean utility room. Also, in the Emergency Department women's examination room, the OIG found an examination table facing the door. The OIG would expect the table to face away from the door to maintain patients' privacy, especially during physical examinations. Because staff promptly corrected the issues, the OIG did not make a recommendation.

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

[40] 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.

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 action when needed.[41] 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.[42] 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.

The OIG reviewed facility policies and memorandums and found staff had standardized processes for communicating test results. However, several were past their designated review dates. Outdated policies and memorandums may not include the correct information for staff to provide safe and appropriate patient care. The Chief of Quality and Patient Safety acknowledged leaders were aware of the issue and staff were actively working to update them. The OIG recommends facility leaders update local policies and memorandums related to the communication of test results.

The OIG also found two memorandums showing executive leaders agreed that leaders needed to conduct institutional disclosures for two patient safety events involving delays with the communication of abnormal test results.[43] Both events occurred in fall 2022, and the memorandums were signed in spring 2023. However, when the OIG requested documentation of the institutional disclosures, quality management staff and facility leaders discovered the disclosures had not been completed. The Risk Manager explained that when facility leaders decide to conduct a disclosure, a risk manager contacts the family to set up an appointment. The Risk Manager said there were shortages in the risk manager positions, which led to the

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

[42] 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.

[43] An institutional disclosure is a formal process by which VA leaders and clinicians inform patients and families that an adverse event has occurred which resulted in, or may result in, serious injury or death. During disclosure, patient recourse and rights are discussed. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

disclosures not being completed. The OIG recommends the Director ensures the Chief of Staff conducts institutional disclosures for applicable adverse events.[44]

Action Plan Implementation and Sustainability

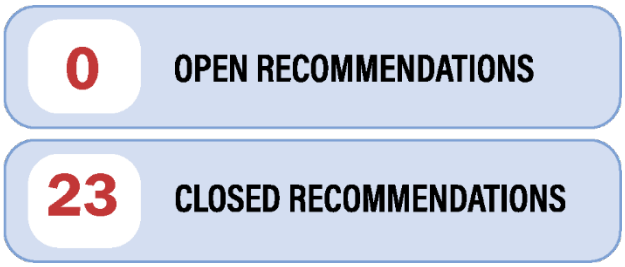


Figure 12. *Status of prior OIG recommendations. Source: OIG analysis of documents.*

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.[45] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG found no open recommendations from a previously published OIG report.[46] The ADNPCS said staff report action plans through the facility's governance structure, and leaders ultimately ensure compliance.

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.[47] 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.[48] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Facility leaders said they identified opportunities for improvement by tracking and trending data related to clinical alerts, surgeries, morbidity and mortality records, patient safety events, peer reviews, and institutional disclosures.[49] The Deputy Chief of Staff identified obtaining timely test

[44] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented prior to the report's publication.

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

[46] VA OIG, *Comprehensive Healthcare Inspection of the Atlanta VA Health Care System in Decatur, Georgia*, Report No. 20-00129-09, November 18, 2020.

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

[48] VHA Directive 1050.01(1).

[49] A peer review "is a critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.

results from community care providers as a challenge.[50] Community care providers could take up to 90 days to send results and sometimes never sent them. The Patient Safety Manager shared that two specialty care clinics had successfully implemented measures to obtain test results in a timely manner: staff asked patients to follow up with the providers and ask them to send the results to the facility, and staff followed up on test results more often and entered delays as adverse events in the patient safety event reporting system.

As an example of how leaders communicated lessons learned, the Patient Safety Manager described a weekly call in which facility leaders, service chiefs, supervisors, managers, and frontline staff discussed patient safety events. The Chief of Quality and Patient Safety explained the call resulted from staff wanting to know the status of follow-up actions for safety events.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[51] 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.[52] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[53] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Prior to the OIG's visit, the facility liaison identified 200 vacancies in primary care positions. During the week of the inspection, the OIG discovered there were 208 vacancies, which included 67 provider, 42 registered nurse, 32 licensed practical nurse, 49 medical support assistant, and 18 pharmacist positions. The Chief Nurse for Primary Care stated that leaders had selected

[50] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed March 5, 2025, https://www.va.gov/CommunityCare.

[51] VHA Directive 1406(1); VHA Handbook 1101.10(2).

[52] 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).

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

candidates for most of the vacant nursing positions, and the Chief of Primary Care said 32 new providers were in various stages of hiring.

Both the Chief Nurse for Primary Care and a primary care physician said the time to bring new employees onboard was the biggest problem with staffing; covering the workload during these delays overburdened current providers, leading some to eventually leave. The Deputy Director informed the OIG that hiring employees took approximately 300 days.

Acknowledging the vacancies, the Director reported the facility had one of the highest veteran-to-employee ratios and was understaffed in comparison to other VHA facilities. Leaders said they received support from Veterans Integrated Service Network (VISN) leaders and human resources employees to reduce hiring timelines, but the volume of open positions posed a significant challenge.[54] According to the ADNPCS, the nurse operations team met weekly with human resources employees to expedite the hiring of candidates. The OIG did not make a recommendation because facility leaders were taking steps to expedite hiring.

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.[55] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[56]

The Chief of Primary Care said 80 percent of physician panels and 21 percent of non-physician panels were above the facility's 115 percent set panel capacity, with the highest at 121 percent. When the OIG asked about panel sizes relative to staffing, primary care employees agreed their panel sizes were excessive. A social worker emphasized that providing quality patient care with current panel sizes was unrealistic, and the Chief Nurse for Primary Care stated some nurses were working with two panels. A primary care physician added that this workload could lead to patient safety issues, such as overlooked laboratory results, unanswered clinical messages, or incorrect medication orders. The physician also highlighted the need to regularly work at home on most nights and weekends, which affected work life balance.

To help manage workload and panel sizes, the Chief of Primary Care discussed strategies such as shifting providers from one panel or clinic to another, paying overtime, and hiring temporary providers. The Chief of Staff mentioned examining teams with excessive panel sizes and offering those veterans appointments with other primary care teams. Additionally, the Chief of Primary Care and the Chief of Staff said they attempted to collaborate with other VHA facilities to enlist

[54] 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/.

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

[56] VHA Directive 1406(1).

providers for virtual care, but the plan ultimately did not come to fruition. The Chief of Staff attributed it to providers from other facilities not having access to the electronic health records.

Although leaders used several strategies to manage teams' workload, the OIG recommends they take additional actions to obtain manageable panel sizes per VHA guidelines and ensure patients have access to high-quality care.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[57] 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.

Primary care leaders and staff stated the number of walk-in patients and increased tasks due to vacancies affected primary care teams' efficiency. The acting Chief of Health Administration Service reported that staff had ordered kiosks to help facilitate patient check-ins and planned to acquire more for clinics to minimize the effects of medical support assistant vacancies.

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. Since the implementation of the PACT Act, the Chief of Primary Care reported more veterans had gained access to care. The OIG reviewed appointment wait time data from October 2022 through March 2024 and found the average time was about six days for established patients and about eight days for new patients.

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

[57] VHA Handbook 1101.10(2).

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[58]

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).[59] 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."[60]

The HCHV program did not meet the HCHV5 target in FYs 2022 or 2023. Program leaders identified the COVID-19 pandemic as a barrier to meeting the target because veterans received housing in hotels during that time, which lowered enrollment. Program leaders described the point-in-time count as useful in providing a true number of veterans living in a wooded area who did not have access to services.

Additionally, a program leader informed the OIG the HCHV program was the umbrella for multiple programs whose staff refer homeless veterans to services in VA and the community. HCHV staff also conduct both community and street outreach to identify and enroll veterans.[61] Program leaders said outreach efforts had been effective due to the increased number of veterans accessing healthcare and housing services. Additionally, several community partners had locations at the facility to assist veterans with obtaining housing, employment, and benefits.

> Program staff shared a story of engaging with a veteran living in a tent. The veteran's spouse, who also lived in the tent, had been diagnosed with cancer. The veteran initially refused housing but eventually agreed to enroll in the program, and expressed gratitude that staff cared.

Figure 13. *Success story of veteran engagement.*
Source: OIG interview.

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

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

[60] 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.

[61] "Community outreach is outreach to Veterans experiencing homelessness taking place in the community-based setting such as shelters, meal sites, homeless Veteran Stand Down events, job fairs, resource and referral centers, and other community outreach events." "Street Outreach is outreach to Veterans experiencing unsheltered, street homelessness taking place in non-traditional settings such as on the street, under bridges, in homeless encampments and in parks or other places not meant for human habitation." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

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).[62] The program did not meet the HCHV1 target in FYs 2022 or 2023. Program leaders shared an example of how some veterans left the program to stay with family and friends, which was not considered permanent housing. The Assistant Chief of Social Work added that the program received a temporary mandate to delay admissions to the traditional housing program due to the high number of veterans who tested positive for COVID-19, which affected the program's ability to meet the performance measure.

The program also did not meet the HCHV2 target in FY 2022 but did in FY 2023. A program leader attributed their FY 2022 performance to incorrectly coded discharges. Leaders reported factors that helped them meet the FY 2023 target included reengaging veterans who were previously discharged, and training staff on ways to reduce negative discharges from the program during bi-monthly meetings. Program leaders also stated challenges for staff to help veterans secure housing included lack of income, legal and mental health issues, and the shortage of community emergency beds, particularly for women. Through interviews, the OIG learned the staff addressed these barriers by collaborating with community partners.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[63] 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.[64]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[65] The Veterans Justice Program exceeded the performance target

[62] 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*.

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

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

[65] 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*.

during each quarter of FY 2023. Program leaders attributed this success to VISN support and engaged staff who worked diligently to enroll veterans into the program.

Program leaders said they receive referrals from facility staff and community partners, as well as from courts and jails. The leaders also said staff conduct community outreach; educate community partners on the program and services offered; and share information at conferences, jails, district attorney offices, and courts to receive program referrals.

The OIG found that program leaders were unaware of the directive published on April 4, 2024.[66] Program leaders obtained the updated directive during the week of the inspection and said they planned to review it and implement changes if needed. Despite concerns about staff being unaware of the updated directive, the OIG found the program met overall goals and made no recommendations.

Meeting Veteran Needs

A program leader outlined program objectives to address veterans' substance abuse, mental health, medical issues, and other determinants that negatively affected their ability to avoid legal involvement. Staff assess veterans' needs once they enroll them in the program, and refer them to veterans treatment courts, substance abuse, or mental health programs as needed.[67]

However, program leaders described challenges in addressing veterans' needs, saying some veterans were not eligible for VA health care. The OIG learned during an interview that there are 17 veterans treatment courts in the program's service area, and staff work closely with court coordinators and judges to assist veterans as needed. Additionally, program leaders highlighted a successful partnership with a local law school in which an attorney and law students provided ongoing, no-cost legal services to enrolled veterans at a VA clinic.

Justice program staff shared a success story about a veteran who, with the support of the Veterans Justice Program, enrolled in veterans treatment court, participated in recommended treatment, and eventually set up a nonprofit organization to address domestic violence.

Figure 14. *Veterans Justice Program success story.*
Source: OIG interview.

[66] VHA Directive 1162.06, *Veterans Justice Programs,* April 4, 2024.

[67] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06.

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."[68] 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.[69]

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).[70] The program did not meet the target in FY 2023. Program leaders told the OIG the metric did not accurately reflect the staff's effort to house veterans because it did not capture the amount or type of work the staff conducted. One leader gave an example of staff taking two hours to complete an application for a visually impaired veteran who did not have all the necessary information.

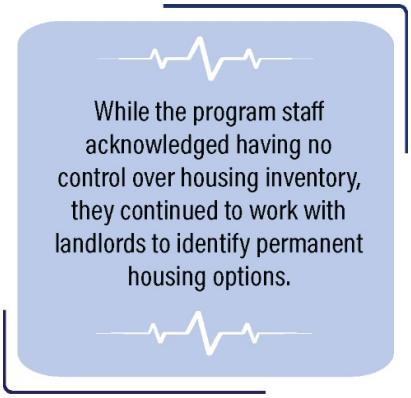


Figure 15. *Staff member's comment on commitment to the homeless program.*

The program leaders stated staff identify and enroll veterans in the program through self-referrals and referrals from the community. Leaders explained that barriers to permanently housing veterans included difficulty obtaining documents, such as birth certificates; limited housing availability; and housing authority delays in processing vouchers. Additionally, leaders shared that birth certificates could take as long as 10 weeks to obtain, and some landlords were unwilling to rent to veterans with legal or credit issues or those with large families. To address barriers, leaders engaged in outreach, developed partnerships with community agencies to streamline the housing application process, and worked with landlords to increase available rentals for veterans.

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

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

[70] 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 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).[71] The program did not meet the target in FY 2023. Program leaders attributed this to a staffing change in the Compensated Work Therapy program. Veterans who participate in the Compensated Work Therapy program need medical clearance prior to staff placing them in an appropriate job. According to program leaders, the loss of the provider, who expedited the clearances, caused them to refer veterans to a primary care provider for clearance, which could require multiple appointments and take up to two months.[72] The OIG recommends facility leaders evaluate and improve processes for medical clearance of veterans who participate in the Compensated Work Therapy program.

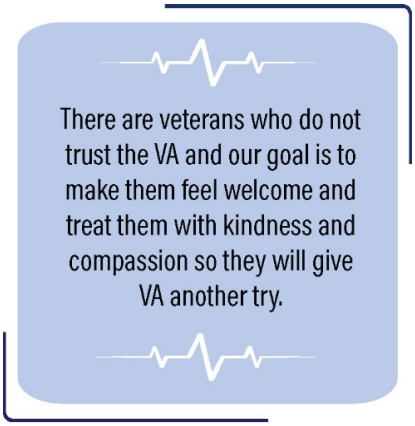


Figure 16. *Staff member's comment on commitment to the homeless program.*
Source: OIG interview.

The OIG learned through an interview that program staff determined the needs of veterans in the program by completing an assessment during admission and then developing a treatment plan. Program leaders said some veterans need finances, food, clothing, and legal assistance. To address veterans' needs, leaders said they use resources through community partners, which included housing through affordable rental units.

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.

[71] 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*.

[72] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment support to Veterans and employers." "Veterans Health Administration, Compensated Work Therapy," Department of Veterans Affairs, accessed July 11, 2024, https://www.va.gov/health/cwt/.

OIG Recommendations and VA Response

Finding: Daily infrastructure issues, including water line breaks and nonfunctioning air conditioning systems, affected patient care.

Recommendation 1

The OIG recommends facility leaders develop and implement a plan to resolve infrastructure issues that affect patient care.

__X__ Concur

____ Nonconcur

Target date for completion: September 30, 2027

Director Comments

The facility concurs with the recommendation. The Associate Director (AD) of Operations is responsible for the implementation and sustainment of this corrective action. The AD of Operations will ensure facility leaders develop and implement a plan to resolve infrastructure issues that affect Veteran care.

The Atlanta VA Healthcare System (AVAHCS) has a robust and structured plan to address infrastructure-related issues. The Engineering Service currently manages 13 design projects and 13 construction projects across various phases aimed at enhancing capital infrastructure. This includes the replacement of 10 air handlers to address air conditioning systems that impact Veteran care. Several air handling units are currently in the design phase and await approval to move into construction. In July 2023, the AVAHCS main hospital's plumbing system became overwhelmed causing leakage in the Medical Intensive Care Unit (MICU) and Radiology Clinic. This issue was resolved by updating all public use toilets with metal trap checks to prevent future blockages, which was completed in December 2023.

All Engineering Service projects are tracked systematically via the Project Tracker report. Each week the Planning, Design, and Construction team meet to review the progress of both the design and construction projects on the tracker. This information is reported bi-weekly to the Veteran's Integrated Service Network (VISN) 7 to ensure leadership is informed on project status and funding allocation. Each month the Chief Engineer also meets with the AD of Operations and the Executive Leadership Team (ELT) to review the status of high priority projects that are identified within the Planning, Design and Construction team meetings. These updates are reported to VISN 7 via the monthly Management Briefing to ensure enterprise-wide transparency and alignment with capital infrastructure goals. This systematic approach ensures sustained oversight for the AD of Operations to ensure resolutions to infrastructure issues that affect Veteran care.

Finding: Leaders were aware of veterans' concerns about unanswered calls and difficulties in reaching healthcare providers but had not resolved them.

Recommendation 2

The OIG recommends facility leaders develop and implement a plan to resolve veterans' unanswered phone calls and inability to reach staff.

__X__ Concur

____ Nonconcur

Target date for completion: May 31, 2025

Director Comments

The facility concurs with the recommendation. The Associate Director (AD) of Access is responsible for the implementation and sustainment of this corrective action to ensure resolution to Veterans' concerns regarding unanswered calls and difficulties in reaching healthcare providers. Under the direction of the AD of Access, Health Administration Service (HAS) developed a plan to dissolve the Patient Scheduling Center and return Veteran calls back to the points of care within the facility utilizing Automatic Call Distribution (ACD) lines. HAS established an Interdisciplinary Project Team (IPT) to develop a sustainable plan to execute the redirection of calls, schedule appointments, and monitor the Mental Health scheduling center and support staff related to facility phone operations. The IPT effectively assessed operations, underwent planning, and initiated staff training by January 2025. Staff transitioning from the Patient Scheduling Center to the points of care began on April 7, 2025. As of April 15, 2025, staff training and transitions remain underway and full implementation of the new call process is expected by May 31, 2025.

This IPT, meets bi-weekly to manage and track the process to closure. The IPT reports monthly to the Veteran's Integrated Service Network (VISN) 7 and the Atlanta VA Healthcare System's (AVAHCS) Quality and Patient Safety Executive Council (QPSEC). The QPSEC reports monthly to the Executive Leadership Board (ELB), which includes membership of the AD of Access. This systematic approach to monitoring this process provides sustained oversight for the AD of Access to ensure resolution to Veterans' unanswered phone calls.

In December 2024, the facility developed and distributed the one-page "Save a Trip" directory to ensure Veterans' are provided the necessary contact information to reach staff. This document also serves as an informational guide with answers to the most frequently asked questions. This is a living document that is updated regularly by organizational leaders and redistributed as needed to ensure Veterans consistently have the most up-to-date information and telephone numbers available to them.

Finding: Emergency call boxes were out of order, with signs instructing veterans to call the police if they needed assistance.

Recommendation 3

The OIG recommends facility leaders replace the emergency call boxes in the parking garage to ensure they are active and functioning.

__X__ Concur

____ Nonconcur

Target date for completion: January 1, 2026

Director Comments

The facility concurs with the recommendation. The Assistant Director is responsible for the implementation and sustainment of this corrective action. The Assistant Director will ensure facility leaders partner to replace the emergency call boxes to ensure they are active and functioning. As an interim safety measure, the Atlanta VA Health Care System's (AVAHCS) Police Services has placed signage throughout the parking lots advising individuals to call the AVAHCS Police line directly during emergencies, with the police contact number clearly displayed. Polices Services has also secured Veteran Integrated Service Network (VISN) 7 approval and funding to remove and replace all Emergency Call Boxes. The Contracting Officer Representative (COR) is currently in the process of reviewing vendor quotes. Once a vendor is selected, the contracted work will proceed to install fully functioning Emergency Call Boxes. The Assistant Director is managing and tracking this project to closure.

Finding: Local policies and memorandums related to the communication of test results were past their designated review dates.

Recommendation 4

The OIG recommends facility leaders update local policies and memorandums related to communication of test results.

__X__ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The facility concurs with the recommendation. The Chief of Staff (COS) is responsible for the implementation and sustainment of this corrective. The COS will ensure facility leaders update local policies and memorandums related to communication of test results.

An Interdisciplinary Project Team (IPT) for Communication of Test Results comprised of key stakeholders, identified 3 policies as being beyond their review period: Medical Center Memorandum 00-55 Ordering and Reporting Test Results, Medical Center Memorandum 11-13 Reporting of Critical Results of Tests and Diagnostic Procedures and Health Care System Policy 11-78 Patient Identification and Communication of Verbal Orders and Lab Results. Development of a new local policy will be completed in accordance with the VHA Directive 1088(1), *Communicating Test Results to Providers and Patients* to ensure alignment, compliance and overall effective communication of test results. Continuous monitoring will be conducted by the IPT and reported to the COS and Executive Leadership Team regularly until the policy is approved through governance to include recission of outdated policies. The COS will ensure staff education is provided via key stakeholders.

Finding: Staff had not completed institutional disclosures for two patient safety events related to the communication of test results.

Recommendation 5

The OIG recommends the Director ensures the Chief of Staff conducts institutional disclosures for applicable adverse events.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The facility concurs with the recommendation. The Executive Director (ED) is responsible for the implementation and sustainment of this corrective action to ensure the Chief of Staff (COS) conducts institutional disclosures for applicable adverse events.

Institutional Disclosures are completed according the VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*. They are initiated and managed by the Risk Management team. Upon identification of an adverse event that meets the criteria for institutional disclosure. Risk Managers submit a memorandum to the Executive Leadership Team (ELT) requesting authorization to proceed. Once approved, Risk Managers coordinate the disclosure meeting with the patient or personal representative. The meeting is attended by the COS and applicable leaders chosen by the COS on behalf of the organization.

All institutional disclosures are systematically tracked by the Risk Management team and reported to the Clinical Executive Council (CEC) on a quarterly basis. The CEC, chaired by Chief of Staff, reports to the Executive Leadership Board (ELB) monthly, which is chaired by the ED. All reports are recorded in meeting minutes. This process ensures sustained oversight for the ED to ensure the COS conducts institutional disclosures for applicable adverse events.

Given resource challenges at the time of the visit, Risk Management and Patient Safety has since increased their staffing appropriately to permit weekly huddles to occur in order to mitigate possible missed disclosures. Upon review of Joint Patient Safety Events, Risk Management staff completed both institutional disclosures in September 2024.

Requesting closure of this recommendation based on the evidence provided.

OIG Comments

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

Finding: Although facility and primary care leaders implemented several strategies to manage primary care teams' panels, they were unable to maintain them at reasonable sizes.

Recommendation 6

The OIG recommends facility leaders take additional actions to obtain manageable panel sizes per VHA guidelines and ensure patients have access to high-quality care.

__X__ Concur

____ Nonconcur

Target date for completion: December 31, 2025

Director Comments

The facility concurs with the recommendation. The Chief of Staff (COS) is responsible for the implementation and sustainment of this corrective action for facility leaders to take additional actions to obtain manageable panel sizes per VHA guidelines and ensure patients have access to high-quality care.

Panel capacity for general Patient Aligned Care Teams (PACT) carry interfacility differences depending on patient characteristics and the level of system support. PACTs with patient populations reflecting the established norms for disease severity and reliance on VHA services, and with a staffing model of three (3.0) support staff and 2.0-2.5 exam rooms per full-time equivalent primary care direct patient care provider, an average panel size of 1,200 patients is the target. This is in alignment with the VHA Directive 1406, *Patient Centered Management Module*

(PCMM) for Primary Care. Table 1 within the directive further outlines parameters for panel capacity adjustments that range from –10% to +10%.

Atlanta is authorized 130 PACTs for our size and complexity, and there are 111 PACTs with 108 panels over panel capacity. Efforts to achieve and maintain panel sizes within the parameters outlined in VHA Directive 1406 include hiring additional staff to fill multiple identified vacancies for providers, Registered Nurses, Licensed Practical Nurses, Medical Support Assistants, and Pharmacists. The Primary Care Management Module (PCMM) team members and Primary Care Service Line leadership convene weekly to plan, monitor, and evaluate additional strategies to improve panel size and ensure Veterans have access to high-quality care. Progress is reported to the COS regularly until this action is closed.

Finding: After the loss of a provider who completed medical clearances for employment through the Compensated Work Therapy program, staff referred veterans to primary care providers for clearance, which required multiple appointments and could take up to two months.

Recommendation 7

The OIG recommends facility leaders evaluate and improve processes for medical clearance of veterans who participate in the Compensated Work Therapy program.

__X__ Concur

____ Nonconcur

Target date for completion: July 31, 2025

Director Comments

The facility concurs with the recommendation. The Chief of Staff (COS) is responsible for the implementation and sustainment of this corrective action. The COS will ensure facility leaders evaluate and improve processes for medical clearance of Veterans who participate in the Compensated Work Therapy (CWT) program. Reasons for noncompliance were considered in development of this plan. At the time of survey, the Atlanta VA Health Care System (AVAHCS) had recently experienced a provider vacancy, impacting the medical clearance process for veterans participating in the CWT program.

Since survey, the AVAHCS has streamlined and standardized the clearance workflow. For Veteran's enrolled in the Transitional Work Program under CWT there are two processes outlined if the Veteran has medical concerns that require clearance. If a VA provider is assigned to the Veteran, a consult is routed to their assigned Patient Aligned Care Team (PACT) for evaluation. If the Veteran does not have an assigned VA provider, the consult is routed to the Homeless PACT. In either instance, once the consult is processed, the Veteran is then sent to complete lab work and a nurse visit is scheduled. The PACT provider completes medical

clearance within two weeks of lab completion depending on the lab results and the outcome of the nurse visit.

For mental health (MH) clearance, the Mental Health Front Door clinic is notified via the "CWT/TW Referral" consult. If a MH evaluation is required, the consult is reviewed and scheduled accordingly. The MH clearance is documented through a comment on the consult. The Trauma Recovery Medical Director monitors referrals weekly to ensure timely completion of MH evaluations. In cases of delay, the Trauma Recovery Medical Director directly intervenes to coordinate care.

Currently, the full process for both medical and MH clearance is completed within an average of 2.5 weeks, based on the Veteran's specific needs. A formal Standard Operating Procedure (SOP) is under development to further standardize this process for all stakeholders. This action is being tracked to closure by Primary Care and Mental Health with a target completion date of July 31, 2025.

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. 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.*[2]

Potential limitations include self-selection bias and response bias of respondents.[3] 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 June 25 through 27, 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[4] The OIG reviews available evidence within a specified

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

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

[3] 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.

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

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

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

Appendix B: 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: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 5, 2025

From: Director, VA Southeast Network (10N7)

Subj: Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia

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

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

1. We appreciate the opportunity to review and comment on the OIG Draft Report - Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia. I have completed a full review of the draft report and concur with the findings. We are committed to ensuring Veterans receive quality care that utilizes the high-reliability pillars, principles, and values.
2. I concur with the recommendations and action plan submitted by the Atlanta VA Healthcare System. I also concur with the Atlanta VA Healthcare System's request for closure of Recommendation 5.
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
Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 22, 2025

From: Director, VA Atlanta Healthcare System (508)

Subj: Healthcare Facility Inspection of the VA Atlanta Healthcare System in Decatur, Georgia

To: Director, VA Southeast Network (10N7)

1. I have thoroughly reviewed the draft report from the OIG Healthcare Facility Inspection of the Atlanta VA Healthcare System, conducted from June 25-27, 2024. I want to express my gratitude for the professionalism and dedication demonstrated by the review team. Your commitment to quality improvement and collaborative partnership has been invaluable in helping us grow and enhance our services as an organization. Thank you for the opportunity to evaluate our processes, which is essential in our mission to provide exceptional care to our Veterans.
2. I would like to respectfully request the closure of one recommendation, as we have successfully completed the necessary corrective actions. Attached, you will find our responses and supporting documentation related to recommendation number five.
3. For the remaining recommendations, corrective action plans have been developed and target completion dates are established as detailed in the attached document.
4. Comments regarding the content of this memorandum may be directed to the Chief Nurse of Quality Management.

(Original signed by:)

Mr. Kai D. Mentzer
Executive Director

OIG Contact and Staff Acknowledgments

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