US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia

Healthcare Facility Inspection	24-00617-118	May 22, 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 Augusta Health Care System (facility) from September 24 through 26, 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. The inspection uncovered concerning behavior and communication problems among facility leaders. Through interviews and a facility-wide questionnaire, the OIG learned of facility leaders' threatening and abusive communication style, retaliation for employees sharing concerns with leaders, and a toxic workplace that led to a culture of fear and employees feeling psychologically unsafe.[2]

The OIG reviewed a 2019 OIG report that described concerns regarding facility leaders' inappropriate behavior and unprofessional communication with employees, which had been

[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.

[2] "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.

brought to the attention of facility and Veterans Integrated Service Network leaders.[3] The OIG heard similar concerns during the current inspection, which do not represent a high reliability organization or foster an environment of trust.[4]

VA's All Employee Survey results and interviews with employees supported the general themes of low perceived psychological safety and fear of retaliation.[5] The OIG also found that employees felt supported by their immediate supervisors but lacked trust with facility leaders. This distrust contributed to a negative work environment, and the facility's last place ranking in the VA Organizational Health Index, which measures organizational culture.[6]

The Director said survey scores for fear of reprisal and psychological safety had improved but acknowledged they remained low when compared with other VHA facilities. The Director had developed an action plan to incorporate VA's I CARE (integrity, commitment, advocacy, respect, and excellence) values back into the facility and invest in a program to help leaders build positive relationships with staff.[7]

The OIG also found that veterans had concerns regarding changes in primary care providers. The acting Chief of Staff explained there had been reassignments due to provider resignations and when a new provider started, veterans could continue care with their current primary care team or switch to a new one.

The OIG concluded that facility leaders fostered a culture of fear and hindered open communication and collaboration and made two recommendations to the Under Secretary for Health to review and address leaders' unprofessional behavior and communication, which negatively affected the organizational culture.

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[3] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019. 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/.

[4] High reliability organizations focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings. Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[5] 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.

[6] VA Augusta Health Care System ranked 136th with four other facilities: Sheridan VA Health Care System, VA Atlanta Healthcare System, VA Dublin Healthcare System, and the VA Louisville Healthcare System. "AES Executive Dashboard, 2024 Data + Next Steps," VHA National Center for Organizational Development, https://vaww.ncod.va.gov/AESExecBriefing/#resources. (This website is not publicly accessible.)

[7] "I CARE," Department of Veterans Affairs, accessed January 28, 2025, https://department.va.gov/icare.

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.

The facility consists of the Augusta VA Medical Center (uptown division) and the Charlie Norwood VA Medical Center (downtown division). The OIG physically inspected both and found they were clean, with no privacy concerns. Each main entrance offered clear signage, navigation assistance, and other tools to help veterans with visual and hearing sensory impairments.

However, the OIG found continued supply chain management concerns, which were repeat findings from two prior OIG reports.[8] In the 2020 comprehensive healthcare inspection report, the OIG noted the program that monitored supply levels was not working, the Director was aware, and staff were working to resolve the issues.[9] Additionally, in the 2023 audit report, the OIG noted staffing shortages, inaccurate inventory values, and an increased need for manual counts, which affected efficiency.[10]

Through physical inspections, interviews, and document reviews, the OIG learned facility staff continued to have similar supply issues that affected their ability to provide safe patient care. On the day of the inspection, the OIG informed the Director about the lack of supplies in the Emergency Department and the Medical-Surgical Unit. Multiple staff members said they delayed care to search for supplies. Staff and leaders also reported incidents where providers did not have the supplies they needed to perform procedures, such as a bone drill (needed for a biopsy) which delayed the procedure; a spinal needle (used to inject local anesthetics) that required the provider to use an alternate, less ideal instrument; and a stent (used to keep an artery open) which delayed care and resulted in an urgent procedure and a community care referral for a patient who later died.[11] Although the OIG was unable to determine whether the lack of supplies contributed to the patient's death, a nurse leader said it delayed care.

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[8] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 20-00132-28, December 16, 2020; VA OIG, *Financial Efficiency Inspection of the VA Augusta Health Care System in Georgia*, Report No. 23-00821-01, November 14, 2023. Supply chain management involves processes to purchase, deliver, receive, and dispose supplies. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[9] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia*.

[10] VA OIG, *Financial Efficiency Inspection of the VA Augusta Health Care System in Georgia*.

[11] "Bone Biopsy Technique," Medscape, accessed October 15, 2024, https://emedicine.medscape.com. "Spinal Tap," National Cancer Institute, accessed February 4, 2025, https://www.cancer.gov/dictionaries/terms/spinal-tap. "VA provides care through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed November 20, 2024, https://www.va.gov/CommunityCare.

The acting Chief of Logistics reported that staffing shortages caused supply chain management issues. The nursing staff attempted to resolve the supply concerns in several ways, including entering patient safety event reports when appropriate and emailing facility leaders and the VA central office requesting assistance in obtaining supplies, but were unsuccessful. The OIG remains concerned staff do not have the supplies needed for safe, timely patient care and recommends the Under Secretary for Health ensure Veterans Integrated Service Network and facility directors oversee the inventory management system, resolve medical supply deficiencies, and monitor actions for sustained improvement.

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 that leaders and staff had established a process for communicating urgent, noncritical test results between diagnostic and ordering providers and patients. However, the OIG reviewed audit results for three medical services, identified inconsistent and low compliance rates for communication of test results to patients, and noted that leaders had not developed action plans to address the deficiencies. The OIG was unable to determine if there were any negative patient outcomes related to delayed test result notification. The OIG recommends facility leaders develop action plans to ensure providers communicate test results to patients timely.

The OIG also identified issues with trust between frontline staff and quality management staff, which hindered collaboration on patient safety efforts. The OIG determined that until leaders address these systemic issues, efforts to develop trust between frontline and quality management staff will have limited success.

Additionally, nursing leaders said they did not have access to patient safety reports, which limits their ability to track, trend, and address systems issues that affect patient safety. The OIG also found facility leaders may have missed opportunities to provide patients with institutional disclosures for adverse patient safety events.[12] The OIG made one recommendation to the Under Secretary for Health to direct VHA Quality and Patient Safety Program staff to review the facility's quality management program and determine whether Veterans Integrated Service Network leaders appropriately addressed the issues, and take action as needed.

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

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.[13]

A human resources specialist reported there were 36 vacant primary care positions. The chief and two medical director positions had been vacant longer than 12 months. Leaders described using salary adjustments as well as relocation and retention bonuses as strategies for recruitment. However, the OIG noted an ongoing problem with staff retention, not recruitment. The OIG determined that until leaders address these systemic issues, efforts to fill vacancies will have limited success.

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined that it increased from October 2020 through March 2024. However, the Senior Principal Facility Coordinator reported 34 of the facility's 39 primary care team panels were at or above 100 percent capacity.[14] The acting Chief of Primary Care said the PACT Act did not affect patients' access to care. The OIG confirmed that appointment wait times ranged from 5 to 8 days for established patients, and 5 to 14 days for new patients over the past two years.

Staff reported the workload may have caused providers to miss important clinical alerts (notifications in the electronic health records) or delay their responses to address them. Primary care leaders cited examples to support primary care teams, such as decreasing the number of clinical alerts and hiring additional providers, but primary care staff were unaware of these efforts. The OIG made no recommendation but encourages primary care leaders to communicate frequently and regularly with primary care staff about actions taken to address their concerns.

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 OIG

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

[14] Primary care team panel size, or the number of patients assigned to the team, reflects a team's workload. "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). Modeled panel capacity is "the maximum number of patients a PACT [primary aligned care team] is expected to care for," which is currently set at 1,200. "Panel capacity for general PACTs will vary from facility to facility depending on patient characteristics and level of system support." VHA Directive 1406(1) *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 17, 2024.

found program staff effectively identified and enrolled veterans into homeless programs and met housing, medical, and justice needs.

Program staff participated in outreach and Stand Down events to identify veterans and enroll them in the program.[15] Program staff said they work with community partners to address challenges for veterans, like inadequate public transportation and available housing. The Veterans Justice Outreach Coordinator highlighted an issue with transportation in rural areas. Therefore, a veterans service organization or program staff transported veterans to medical appointments, when needed.[16]

The Housing and Urban Development–Veterans Affairs Supportive Housing program Supervisory Social Worker reported that during the COVID-19 pandemic, it was difficult to find landlords willing to accept the housing vouchers, and therefore, staff focused on outreach and building relationships with landlords to increase their participation in the program. Program staff said the Freedom's Path apartments at the facility's uptown division did not accept their program's housing vouchers.[17] The OIG made no recommendation but encourages facility leaders to take actions to support program voucher acceptance at Freedom's Path apartments.

What the OIG Recommended

The OIG made five recommendations for improvement.[18]

1. The Under Secretary for Health evaluates facility leaders for appropriate supervisory behavior and professional communication and takes actions as needed.
2. The Under Secretary for Health determines whether the Veterans Integrated Service Network Director and other Veterans Integrated Service Network leaders were aware of, but did not address, facility leaders' unprofessional behavior and communication, and takes actions as needed.

[15] Stand Downs are one- to three-day events to conduct outreach and engage homeless veterans and present housing opportunities and treatment. Stand Downs include VA and community services to assist veterans. VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

[16] Veterans service organizations are non-VA, non-profit groups that provide outreach and assistance 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.

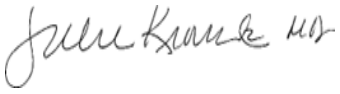
[17] "The Housing Choice Voucher Program (also known as Section 8) helps low-income families, elderly persons, veterans and disabled individuals afford housing in the private market." Local public housing agencies administer Housing Choice Vouchers. "HCV [Housing Choice Voucher] Applicant and Tenant Resources," Department of Housing and Urban Development, accessed October 7, 2024, https://www.hud.gov/hcv/tenants.

[18] The recommendations addressed to the Under Secretary for Health are directed to anyone in an acting status or performing the delegable duties of the position.

3. The Under Secretary for Health ensures the Veterans Integrated Service Network and facility directors oversee the inventory management system, resolve medical supply deficiencies, and monitor actions for sustained improvement.
4. Facility leaders develop action plans to ensure providers communicate test results to patients timely.
5. The Under Secretary for Health directs the national VHA Quality and Patient Safety Program staff to review the facility's quality management program and determine whether actions by facility and Veterans Integrated Service Network leaders effectively addressed system issues affecting patient safety, including nursing leaders' lack of access to safety reports, and missed opportunities for institutional disclosures, and takes action as needed.

VA Comments and OIG Response

The Acting Under Secretary for Health, Veterans Integrated Service Network Director, and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C, D, and E and the responses within the report body for the full text of the Acting Under Secretary for Health and directors' comments). 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

ADPCS	Associate Director for 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 Augusta Health Care System
Augusta, Georgia
Level 1b-High Complexity
Richmond County
Hospital Referral Region: Augusta

Description of Community

POPULATION

Female **523,331**	Male **498,404**
Veteran Female **13,585**	Veteran Male **68,262**

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

MEDIAN INCOME

$44,002

EDUCATION

83% Completed High School
46% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **358**

SUBSTANCE USE

26.2% Driving Deaths Involving Alcohol
17.3% Excessive Drinking
354 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	348,842
Carpool	38,604
Work at Home	17,612
Other Means	6,448
Walk to Work	5,549
Public Transportation	2,615

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**35.5 Minutes, 30 Miles**
Specialty Care	**53 Minutes, 44.5 Miles**
Tertiary Care	**61 Minutes, 56 Miles**

Access to Health Care

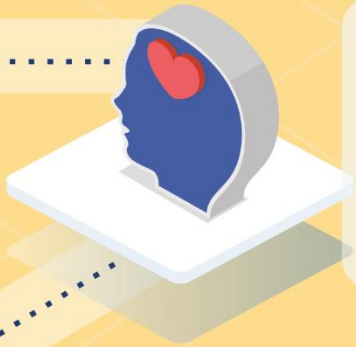
ACCESS

VA Medical Center Telehealth Patients **14,859**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	34%
<65 without Health Insurance	18%

Health of the Veteran Population

137 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

12,265

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.06 Days

30-DAY READMISSION RATE

13%

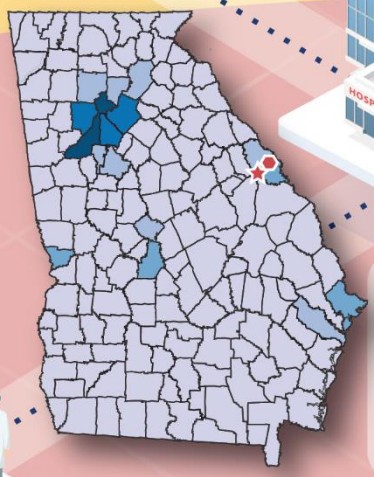
SUICIDE RATE PER 100,000

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

Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	50K
Unique Patients VA Care	48K
Unique Patients Non-VA Care	22K



★ VA MEDICAL CENTER

VETERAN POPULATION

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.53%
Facility Total Loss Rate	13.86%
Facility Retire Rate	2.56%
Facility Quit Rate	10.22%
Facility Termination Rate	0.86%

COMMUNITY CARE COSTS

Unique Patient $19,803	Outpatient Visit $324
Line Item $657	Bed Day of Care $258

⬢ Charlie Norwood VA Medical Center

★ Augusta VA Medical Center

The VA Augusta Health Care System includes the Charlie Norwood VA Medical Center and the Augusta VA Medical Center.

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

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

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]

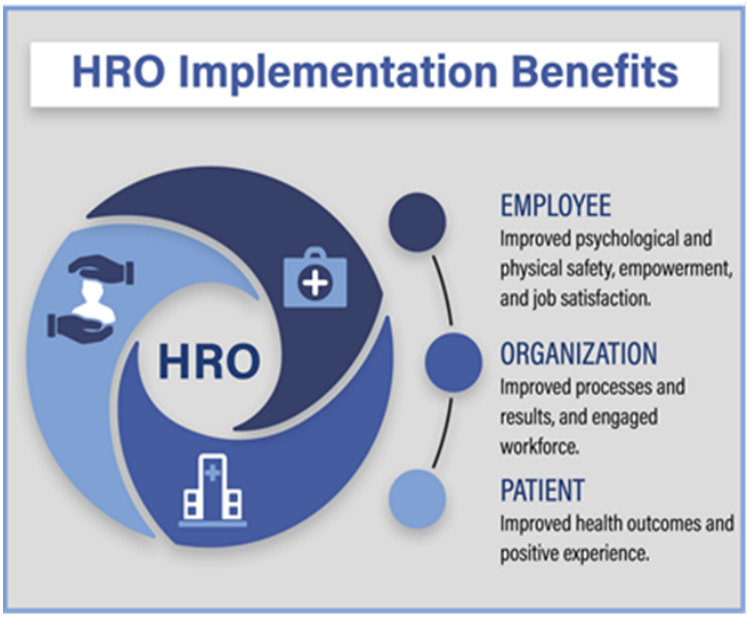


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all

[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.

[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.

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.

[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.

The VA Augusta Health Care System (facility) consists of the Augusta VA Medical Center (uptown division) and the Charlie Norwood VA Medical Center (downtown division). Construction for the downtown and uptown divisions were dedicated in 1980 and 1991, respectively. At the time of the inspection, the facility's executive leaders consisted of the Director, acting Deputy Director, acting Associate Director, acting Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Assistant Director. The current Director has been in the position since April 2018. The facility had 352 operating beds (204 hospital, 88 community living center, and 60 domiciliary beds), and a fiscal year (FY) 2023 medical care budget of approximately $768 million.[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_Community_Living_Centers. 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.

[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. The OIG found that concerning behavior and communication problems among facility leaders had created a toxic workplace. The OIG determined this was a system shock and it will be discussed in detail in the Leadership Communication and Employee Experience sections below.

In the OIG's questionnaire, employees reported the largest system shock as turnover in leadership positions. During the inspection, the OIG noted multiple acting facility leaders, including the Deputy Director, Associate Director, and Chief of Staff. The OIG learned in an interview the permanent Associate Director was the acting Deputy Director, and the permanent Deputy Director and Chief of Staff were temporarily reassigned to assist other VHA facilities.

When interviewed, the Director reported a power outage as a system shock. The Director explained that a utility company error caused the power outage at the downtown division, which lasted approximately two days. The ADPCS assured the OIG that generators were able to provide emergency power to the division, and the outage did not interrupt patient care. The Director added that some staff were aware of the outage but did not know when or how to report the issue, so leaders drafted a new policy to direct emergency communication during significant events. The Director reported placing information and necessary tools, such as flashlights, into yellow boxes for each department in preparation for a future power outage.

The Director also discussed two patient falls that resulted in broken bones as a system shock. To improve patient safety, the ADPCS said a nurse volunteered as the fall prevention coordinator. The fall prevention coordinator worked with staff on a new initiative focused on prevention as opposed to their prior program, which was a reactive approach.

[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]

The facility's All Employee Survey scores for leader communication and information sharing were consistently below VHA averages over the past three years. In an interview, leaders informed the OIG they provided various opportunities for employees to bring concerns directly to leaders. For example, they hosted a weekly meeting, referred to as a Fireside Chat, in which staff could discuss concerns. Leaders also issued a weekly newsletter and visited every location in the facility twice a year to learn about concerns or needs. The ADPCS and the acting Chief of Staff said they hold daily meetings within their departments.

Responses to the OIG questionnaire included less favorable accounts of facility leaders' communication. Respondents described leader communication as unclear, infrequent, and not useful. Employees said leaders' communication style often seemed unprofessional, aggressive, hostile, abusive, coercive, toxic, contentious, threatening, and dictatorial. One staff member said the acting Deputy Director screamed at them and treated them as if they were insignificant in front of others. Employees also mentioned the Fireside Chats were not informative and did not address their concerns.

Throughout the inspection, employees reported concerns about leaders' communication style to OIG team members. For example, a staff member said that in a meeting, the Director aggressively criticized a Veterans Integrated Service Network (VISN) staff member and then yelled at everyone, except other facility leaders, to leave the room.[23] During interviews, the OIG

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[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] 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/.

learned the Director had strong feelings about healthcare operations, which impeded collaboration. For example, a clinical leader said the Director became angry if leaders made clinical decisions the Director did not agree with or if they asked clarifying questions to understand the Director's preferences. Staff made additional comments about interacting with leaders during interviews with the OIG:

- Facility leaders do not allow for autonomy within departments
- Staff are unsure of the response they are going to receive
- A leader scolded a staff member like a child during a call

The OIG noted that these statements do not represent HRO strategies to build trust or shape a forthright culture.[24] A 2019 OIG report issued to the facility had similar findings, noting they exposed a facility with organizational division and communication dysfunction where:

> some clinical managers did not feel heard or supported by members of the leadership team, and failures to adequately address a range of long-term problems resulted in situations that angered staff, jeopardized relationships and partnerships, and placed patients at risk.[25]

In a 2019 OIG report, one manager stated, "my impression is that there is a lot of intimidation, undermining and disrespect being demonstrated by the ELT [executive leadership team]."[26]

The Director provided the following response to the OIG regarding communication:

> All of my meeting[s] with staff are through the Fireside Chat and formal meetings that are recorded, so staff can listen to them at a later date. My one-on-one communications are with the senior members of the team, and I always have a second person present to capture the conversation. I am not aware of any reports to me or my supervisor concerning my communication style. I am specifically mindful of my communication with staff and ensure that I do not cross into any aggressive or offensive communication. I am confident no one in this facility can truthfully state I have treated them with anything less than full respect.

When the OIG asked the Director to respond to staff's comments describing leaders' aggressive communication styles, the Director admitted to being aware of some complaints. The Director

[24] Department of Veterans Affairs, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, March 24, 2022.

[25] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*, Report No. 19-00497-161, July 11, 2019.

[26] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*.

reported investigating the issue and taking disciplinary or corrective actions in several cases in response to these concerns.

In the facility's 2019 report, the OIG made a recommendation to the VISN Director to evaluate the quality and professionalism of facility leaders' communications and to act as needed.[27] However, in the OIG questionnaire and during interviews, employees indicated facility leaders had not changed their communication styles.

The OIG noted the prior report's recommendation to the VISN Director did not appear to be resolved during this inspection, and a culture of safety relies on consistent, respectful, and bidirectional communication. Therefore, the OIG recommends the Under Secretary for Health evaluates facility leaders for appropriate supervisory behavior and professional communication and acts when indicated. Further, the OIG recommends the Under Secretary for Health determines whether the VISN Director and other VISN leaders were aware of, but did not address, facility leaders' unprofessional behavior and communication, and takes actions as needed.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[28] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[29] 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.

In interviews with facility leaders, the OIG asked about trends for their All Employee Survey scores for psychological safety and fear of reprisal for the past three years.[30] The Director said the scores had improved but remained low when compared to other VA facilities. The Director highlighted their investment in a toolkit to address low psychological safety scores and improve teamwork processes by building positive relationships, adding that leaders had been trained on

[27] VA OIG, *Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia*.

[28] "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.

[29] 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.

[30] The All Employee Survey questions for workgroup psychological safety and no fear of reprisal are "Members in my workgroup are able to bring up problems and tough issues" and "I can disclose a suspected violation of any law, rule or regulation without fear of reprisal." "AES Questions by Organizational Health Framework."

how to use the tool, and frontline employees would be trained beginning the following November.

The Director also spoke about an action plan drafted to improve the survey scores for the next year, which included upholding VA's I CARE (integrity, commitment, advocacy, respect, and excellence) values and promoting transparency and accountability.[31] However, the OIG learned from an interview the action plan was drafted without the assistance of the other facility leaders.

The OIG noted a general theme during interviews with employees, who described feeling supported and psychologically safe with their first-line supervisors but not with facility leaders. For example, the homeless and justice program employees stated they feel psychologically safe with other program employees and with their service chief but not with facility leaders. Primary care employees said they feel facility leaders do not care about them, despite the appearance of being present for employees.

As discussed previously in the Leadership Communication section, employee questionnaire responses and interview statements indicated that employees' experiences vastly differ from leaders' perceptions. Employees made additional comments regarding their experiences:

- Facility leaders foster a punitive environment
- The Director is not supportive and insults people
- Employees fear becoming the scapegoat for poor patient outcomes caused by system deficiencies
- Employees walk around on pins and needles

Employees discussed instances where the subject matter expert was not involved in decisions or leaders ignored them, which directly affected patient care. An employee described a situation where the acting Deputy Director did not follow the subject matter expert's guidance for clinic schedules, which resulted in appointment slots outside of providers' working hours or overlapping, and overbooked providers, requiring employees to reschedule patients. The OIG concluded the acting Deputy Director's refusal to consider subject matter expertise contributed to low employee satisfaction and patient safety concerns.

Retaliation is also a recurring theme in questionnaire responses and interviews. Employees alleged that reporting concerns is met with retaliation from the Director in the form of removal from positions, reassignment to other facilities, and punitive investigations by administrative boards and outside entities. Employees reported feeling fearful of losing their jobs if they speak out or ask for help.

[31] "I CARE," Department of Veterans Affairs, accessed January 28, 2025, https://department.va.gov/icare.

Additionally, questionnaire respondents identified poor leadership and feeling disrespected at work as reasons they would consider leaving the facility. An employee submitted their resignation due to facility leaders not respecting or valuing employees and believing attempts had been made to cover up wrong doings. Another employee recounted situations where employees had left the facility due to leaders' micromanagement and the perception that employees could not do their jobs. The OIG reviewed a document provided by a manager that revealed some staff reported a hostile work environment as the reason for their departure during exit interviews.

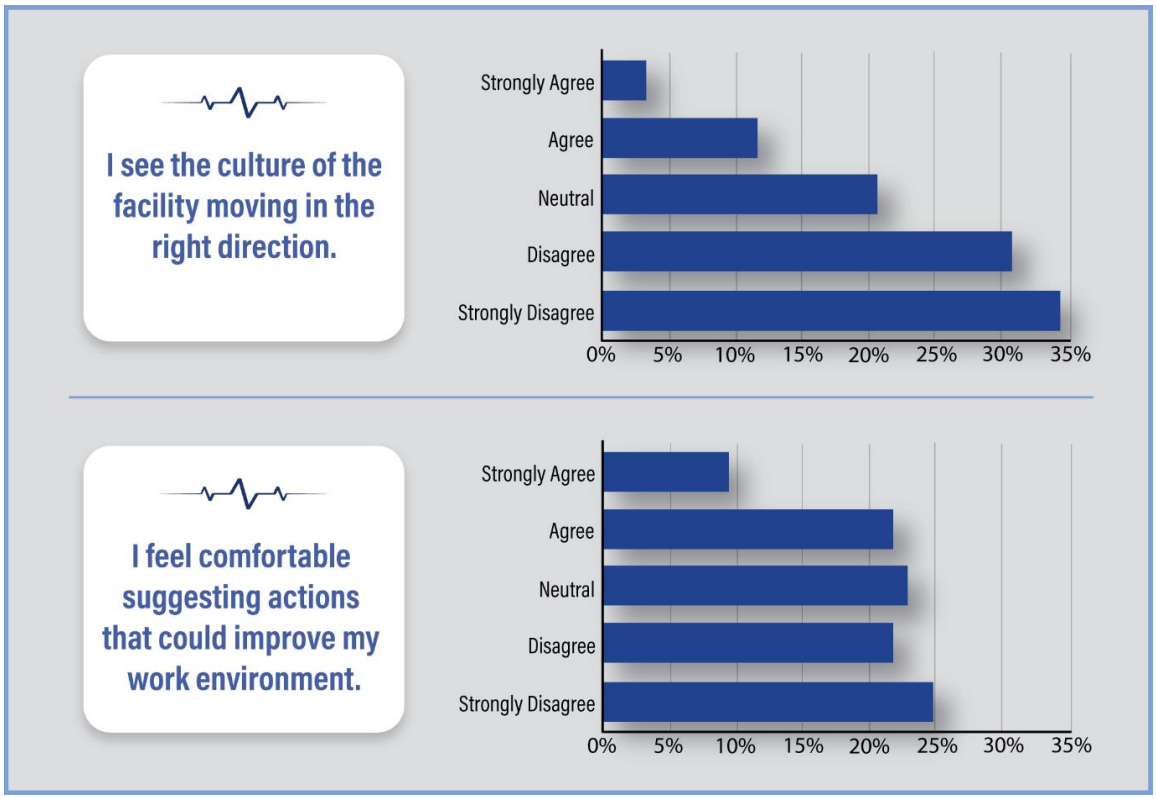

Figure 4. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

When the OIG asked facility leaders about the questionnaire responses exhibited in figure 4, the Director stated:

> Without having the data to look into that, I would need to drill down into that and know where they [respondents] are because as I mentioned on the first day, we have pockets of areas…[where]…people are very, very happy and…we have pockets where they are not very, very happy. So, I'd like to be able to correlate where those are coming from…because we know where we have areas that we have to target.

The OIG also reviewed the All Employee Survey's 2024 Organizational Health Index, which is an indicator of the culture, and noted the facility ranked 136th among VHA facilities, along with

four others.[32] VHA determines index scores by comparing each facility to all other facilities across 73 measures. The facility had a score with 0 favorable, 6 neutral, and 67 unfavorable comparisons. Examples of unfavorable comparisons included employees' experiences of burnout, perceptions of supervisor fairness, and transparent communication from supervisors.[33]

The OIG concluded that facility leaders had misperceptions about employee satisfaction, and the facility's culture was not psychologically safe. The OIG recommends the Under Secretary for Health evaluate facility leaders' unprofessional behavior and communication (see the Leadership Communication section above). The OIG determined that until VHA leaders address these systemic issues, the facility will have low employee satisfaction, and a psychologically unsafe culture.

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.[34] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[35] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In reviewing questionnaire responses from patient advocates and VSOs, the OIG noted veterans' concerns about changing primary care providers. Leaders reported being aware of the issue, and the acting Chief of Staff explained that when providers resign, staff assign veterans to another primary care team. When a new provider becomes available, staff notify the veterans, who could choose the new provider or stay with their current team.

[32] VA Augusta Health Care System ranked 136th with four other facilities: Sheridan VA Health Care System, VA Atlanta Healthcare System, VA Dublin Healthcare System, and the VA Louisville Healthcare System. "AES Executive Dashboard, 2024 Data + Next Steps," VHA National Center for Organizational Development, https://vaww.ncod.va.gov/AESExecBriefing/#resources. (This website is not publicly accessible.)

[33] "AES Executive Dashboard, 2024 Data + Next Steps," VHA National Center for Organization Development. Burnout is when employees feel overworked and exhausted in their professional life. "Burnout and Resilience: Frequently asked Questions," Department of Veterans Affairs, accessed January 18, 2025, https://www.va.gov/BurnoutResilience.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[36] 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.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[37] 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.[38]

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.

The OIG inspected the facility's uptown and downtown divisions. The OIG

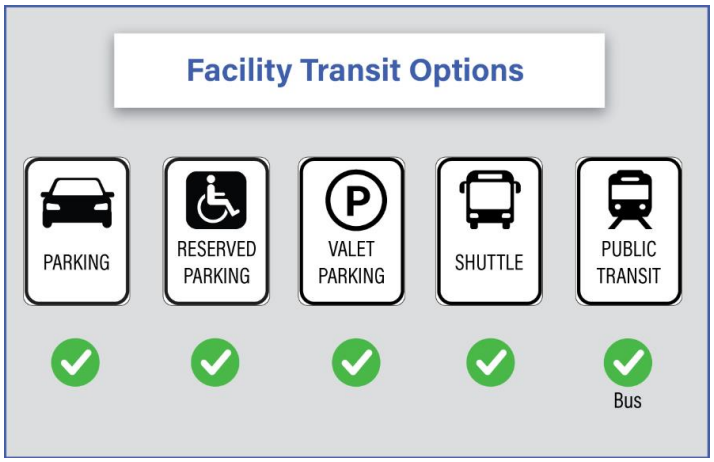

Figure 5. *Transit options for arriving at the facility.*
Source: OIG observations and analysis of documents.

[36] VHA Directive 1608(1).

[37] 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.

[38] 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.

accessed directions to both locations from the facility's website. The directional link to the downtown division provided the OIG with accurate directions; however, the OIG had to enter the address in the map when using the link to the uptown division. The OIG observed signs leading veterans to parking lots at both divisions. Each division had parking lots with ample spaces and lighting. Veterans had public transit options to reach both divisions, as well as a shuttle that provides transportation between them.

Main Entrance

Figure 6. *Front entrance of the facility's downtown division.*
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.[39]

The main entrance at each division featured an extended roof and sheltered drop-off area. Inside each division's main entrance, the OIG noted power-assisted doors and available wheelchairs. Both entrances were well-lit; had natural lighting; and featured staffed information desks, seating, and areas offering food and drink.

Navigation

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

The OIG observed tools at both divisions that allowed veterans to effectively navigate the facility, including large digital kiosks, and a VA wayfinding application for smartphones. The OIG also observed staff escorting veterans to their destinations at both divisions. Additionally, the OIG noted large wall maps and directional signs at intersections within each division.

[39] 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*.

[40] 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.[41] The OIG observed large print on the wall maps and braille in the elevators at both divisions. The OIG reviewed documentation from the Chief of Audiology and Speech Pathology that showed assisted listening devices were available to help hearing impaired veterans. Additionally, the smartphone wayfinding application guided veterans to locations with audible and visual directions.

Figure 7. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations and interviews.

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.[42] The OIG learned the facility had two full time navigators and wait times for toxic exposure screenings were less than 30 days.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[43] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations

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

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

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

from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed two prior OIG reports that contained supply chain management findings for the facility: a 2020 comprehensive healthcare inspection report and a 2023 audit report.[44] Table 1 below provides an overview of the findings.

Table 1. Supply Chain Findings from Previous OIG Reports

OIG Report	Supply Chain Management Concerns
2020 OIG Comprehensive Healthcare Inspection Program report, *Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia*	Staff using supply cabinets in the intensive care unit and in the post-acute care unit reported that "they beep 'all the time' and fingerprint access had not been functional for approximately three years. In each of the patient care areas inspected, OIG staff confirmed that remote monitoring of supply levels was not working and could inadvertently lead to an inadequate supply of patient care items and undetected loss or misuse. When questioned, the Director indicated awareness and reported that not all machines were initially connected to the network, logistics staff were receiving training for the equipment, and a team of staff were working to resolve the issues."
2023 OIG report, *Financial Efficiency Inspection of the VA Augusta Health Care System*	"…healthcare system inventory managers failed to routinely monitor reported conversion factor errors and properly record supplies moving in and out of the three inventory points the team reviewed. This led to increased reliance on manual counts, inaccurate inventory values, and use of manual adjustments to correctly record inventory....In addition, staffing shortages may have affected the ability of the healthcare system to conduct key supply chain management oversight, establish and follow internal controls, and achieve or maintain efficiency."

During the current inspection, the OIG found repeat findings from the two reports related to supply chain management issues that affected staff's ability to provide safe patient care. Additionally, multiple responses to the OIG questionnaire identified the lack of supplies as an ongoing issue.

The OIG reviewed the delivery systems and available supplies for each unit inspected to ensure leaders had resolved the deficiencies identified during the prior two inspections. The OIG physically inspected several supply closets and found those in the Emergency Department and Medical-Surgical Unit did not contain some medical supplies. Staff reported ongoing issues that required them to leave the units in search for necessary supplies, delaying the safe and efficient delivery of patient care. The acting Chief of Logistics reported that staffing challenges had

[44] Supply chain management "is the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities." VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020. VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia*, Report No. 20-00132-28, December 16, 2020; VA OIG, *Financial Efficiency Inspection of the VA Augusta Health Care System in Georgia*, Report No. 23-00821-01, November 14, 2023.

affected their ability to properly manage supply closets. However, at the time of the inspection, five supply technicians were in various stages of the hiring process.

Various staff reported actions taken to resolve supply issues without success:

- A nursing team had attempted to streamline supply requests through instant messaging
- Nursing staff frequently discussed the topic during a daily call with the ADPCS
- Nurse managers from the Emergency Department, Intensive Care Unit, and Medical-Surgical Unit had informed facility leaders about the lack of supplies
- Nursing staff entered patient safety reports on the lack of supplies affecting patient safety
- A staff member emailed facility leaders and VA's central office requesting assistance in obtaining supplies to prevent the cancellation of procedures

An Emergency Department staff member reported that a physician needed to insert a Foley catheter (used to drain urine from the bladder), and the patient waited about an hour before staff could locate the supplies for the procedure.[45] If a person is unable to empty their bladder, it could result in pain, discomfort, kidney swelling, bladder damage, and infection.[46]

An Assistant Nurse Manager in the Emergency Department reported not having pulse oximetry monitors to measure patients' oxygen saturation levels.[47] Additionally, the assistant manager said when the Emergency Department received a supply of pulse oximetry monitors, they reserved them for respiratory patients and sometimes the monitors, which were intended to be single use items, had to be wiped down and reused.

An Intensive Care Unit nurse stated they did not have Ambu bags at patient bedsides for approximately four hours, and they would have had to use bags from crash carts until the supplies arrived.[48] Hospitals keep Ambu bags at the bedside in critical care areas to ensure quick

[45] A Foley catheter is a tube to allow for urinary drainage. *Merriam-Webster*, "Foley Catheter," accessed October 7, 2024, https://www.merriam-webster.com/dictionary/Foleycatheter.

[46] "Medical Student Curriculum: Bladder Drainage," American Urological Association, accessed October 10, 2024, https://www.auanet.org/medical-students-curriculum/bladder-drainage.

[47] "Pulse Oximetry," American Lung Association, accessed October 25, 2024, https://www.lung.org/lung-health-diseases/procedures-and-tests/pulse-oximetry.

[48] An "[a]mbu bag is a handheld device used in emergency situations for patients who are not breathing…or who are not breathing adequately." K. Ernstmeyer and E. Christman, "Oxygen Therapy," chap. 11 in *Nursing Skills [Internet]*, (Eau Claire, WI: Chippewa Valley Technical College, 2021), https://www.ncbi.nlm.nih.gov/NBK593208/.

access during emergencies. Without bedside availability, staff would need to leave the areas to locate one, potentially delaying life-saving procedures such as cardiopulmonary resuscitation.[49]

The same Intensive Care Unit nurse reported low levels of continuous renal replacement therapy cartridges for bedside dialysis machines to supply chain management staff but did not receive the supplies.[50] The nurse escalated the concern by contacting the after-hours supply chain management supervisor, but staff were unable to resolve the issue until the following day. The nurse stated the lack of cartridges delayed a patient's dialysis treatment for several hours.[51] The nurse added there was no known harm to the patient; however, missing dialysis can lead to severe health problems.[52]

A Medical-Surgical Unit nurse said a nurse was unable to administer insulin to a patient because there were no lancets (used to test blood sugar levels) available for approximately 24 hours.[53] Patients who do not receive insulin at the appropriate time could experience diabetic complications.[54]

The acting Deputy ADPCS reported an incident in which the Interventional Radiology department lacked bone drills (designed to capture bone pieces during a biopsy), which delayed a patient's procedure.[55] Generally, postponing a biopsy may delay a patient's diagnosis and treatment.

An operating room staff member stated that inventory management staff were not aware spinal needles (used to inject local anesthetic) were available, and the acting Deputy ADPCS said this affected operating room procedures.[56] The operating room staff member notified facility leaders via email of an incident in which operation room staff requested spinal needles, but a supply

[49] Cardiopulmonary resuscitation is a procedure designed to restore normal breathing. *Merriam-Webster* "Cardiopulmonary Resuscitation," accessed October 28, 2024, https://www.merriam-webster.com/CardiopulmonaryResuscitation.

[50] "Continuous renal replacement therapy (CRRT) is a form of renal replacement therapy that is used in modern intensive care units (ICUs) to help manage acute kidney injury (AKI), end stage kidney disease (ESKD), poisonings, and some electrolyte disorders." Samir C. Gautam, Jonathan Lim, and Bernard G. Jaar, "Complications Associated with Continuous RRT," *Kidney360* 3, no. 11 (November 24, 2022): 1980-1990, https://journals.lww.com/kidney360/complications.

[51] "Dialysis…perform[s] normal kidney functions, filtering waste and excess fluid from the blood." "Dialysis," Cleveland Clinic, accessed December 2, 2024, https://my.clevelandclinic.org/dialysis.

[52] "Missing Dialysis Treatment Is Dangerous for Your Health," National Kidney Foundation, accessed October 10, 2024, https://www.kidney.org/missing-dialysis-treatment-dangerous-your-health.

[53] "Blood Sugar Monitoring," Cleveland Clinic, accessed October 28, 2024, https://my.clevelandclinic.org/blood-sugar-monitoring.

[54] Paula M. Trief et al., "Incorrect Insulin Administration: A Problem that Warrants Attention," *Clinical Diabetes* 34, no. 1 (January 1, 2016): 25–33, https://doi.org/10.2337/diaclin.34.1.25.

[55] Medscape, "Bone Biopsy Technique," accessed October 15, 2024, https://emedicine.medscape.com/BoneBiopsyTechnique.

[56] National Cancer Institute, "Spinal Tap," accessed February 4, 2025, https://www.cancer.gov/spinal-tap.

technician did not know the items were in stock, resulting in delayed delivery. Additional email communication provided to the OIG also noted that during the preparation of an operating room, staff discovered expired supplies in storage. This situation required the provider to use an alternative instrument to complete the procedure, which an operating room staff member described as less than ideal.

A Chief Nurse described a patient case from the prior year that nursing staff presented to facility and quality management leaders in which the unavailability of a stent (a small tube used to keep an artery open) led to a delay in care and the need for an urgent procedure and a community care referral.[57] The patient later died, and although the OIG was unable to determine whether the unavailable supplies contributed to the death, the acting Deputy ADPCS identified the lack of supplies contributed to a delay in care.

During the inspection, the OIG informed the Director about the lack of supplies in clinical areas. The next day, the OIG spoke with the Director, who reported that facility leaders had visited the units after being informed of the supply shortages. The Director said supplies were not located in the supply closets but were stored in various other areas within the units, and staff were hoarding supplies. However, the ADPCS denied hoarding was an issue and stated that although staff kept some supplies outside of the supply closets, supply chain management staff's lack of supply inventory knowledge, unwillingness to deliver supplies to units, and staffing shortages were the main problems. Additionally, a nurse told the OIG the PAR Excellence inventory system does not alert staff when supplies are low.[58]

The OIG revisited the Emergency Department and the Medical-Surgical Unit the day after the initial physical inspection to follow up with staff and confirm whether the missing supplies were addressed by facility leaders. Multiple staff members reported that various facility leaders came to the areas and took pictures of the supply closets but did not approach them to discuss supply needs or concerns.

The acting Associate Director provided the OIG with documentation from a December 2023 VISN Issue Brief stating the facility was overspending on supplies due to an error in the PAR

[57] National Heart, Lung, and Blood Institute, "What Are Stents," accessed January 23, 2025, https://www.nhlbi.nih.gov/health/stents. "VA provides care through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed November 20, 2024, https://www.va.gov/COMMUNITYCARE.

[58] The PAR Excellence electronic inventory system is a weight-based system that automatically senses which items and how many are dispensed. "PAR Bins Weight-Based Inventory Management System," PAR Excellence, accessed October 28, 2024, https://parexcellence.com/products-par-bins.

Excellence electronic inventory system.[59] VISN staff identified the error and suggested taking the system offline.

The OIG remains concerned staff do not have the supplies needed for safe, timely patient care and recommends the Under Secretary for Health ensures VISN and facility directors oversee the inventory management system, resolve medical supply deficiencies, and monitor actions for sustained improvement.

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 reviewed five clinical areas, two at the uptown division and three at the downtown division, and found the areas to be generally clean and without privacy issues. The OIG found outdated preventive maintenance stickers in all inspected areas, but because staff corrected the problems immediately, the OIG did not make a recommendation.

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.[60] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[59] Issue briefs provide facility, Veterans Integrated Service Network, and VHA leaders clear, concise, and accurate information about a situation or an event. Department of Veterans Affairs, "Assistant Under Secretary for Health for Operations (15), Guide to VHA Issue Briefs," updated April 6, 2022. VA Augusta Health Care System, "VHA Issue Brief, Negative Secondary Item Balance (PAR Ex)," December 21, 2023, updated September 6, 2024. (This Issue Brief is not publicly accessible.)

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

diagnostic and ordering provider teams and their patients.[61] 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 found facility leaders had a process to communicate urgent, noncritical test results. Leaders said the process includes direct and prompt communication between diagnostic and ordering providers and patients; surrogate assignments where specific providers are designated to cover for providers who are out; a cascade notification system used when ordering providers are unavailable; a follow-up system for results ordered by providers who had permanently left the facility; and clear parameters for notifying patients through various means within time frames specified by VHA Directive 1088(1), including face-to-face communication, phone calls, and notification letters.[62]

The OIG reviewed documentation and interview responses related to communication of test result audits for the Ear, Nose, and Throat; Urology; and Primary Care services. The compliance rates for timely provider-to-patient notification were as follows:

- Ear, Nose, and Throat averaged 50 percent compliance for the past 8 months
- Urology compliance ranged from 20 percent to 58 percent over the past 11 months
- Primary Care compliance was approximately 50 percent for the past 8 months

Although the acting Chief of Primary Care acknowledged the audit results demonstrated an opportunity to improve communication of test results, facility leaders did not have action plans to raise the compliance rates. When providers fail to notify patients of test results timely, they may delay follow-up or treatment.[63] The OIG was unable to determine if there were any negative patient outcomes related to delayed notification of test results. The OIG recommends facility leaders develop action plans to ensure providers communicate test results to patients timely.

[61] 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.

[62] VHA Directive 1088(1).

[63] Murphy, Singh, and Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective."

Action Plan Implementation and Sustainability

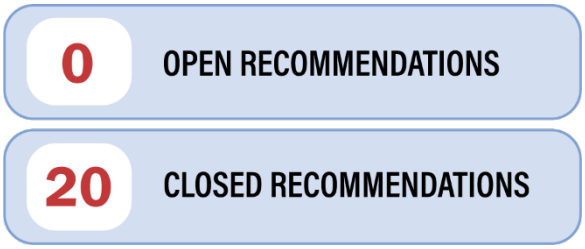

Figure 8. *Status of prior OIG recommendations. Source: OIG analysis of a previous OIG report.*

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.[64] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether action plans were implemented, effective, and sustained. The OIG reviewed a previously published OIG report and found no open recommendations.[65]

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.[66] 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.[67] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In an interview with the OIG, a patient safety manager shared that when patient safety managers identify repeated patient safety trends, they complete a proactive risk assessment, launch an improvement project if necessary, and share information through a group chat and Patient Safety Forum meetings.

The Performance Improvement Coordinator pointed out that it took time to build trust with frontline staff as they did not have experience working with quality management staff on improvement efforts. The coordinator added that quality management staff were trying to establish rapport and trust with frontline staff during projects. As described in the Culture section of this report, staff reported fear of reprisal and a lack of psychological safety, and until leaders address these systemic issues, quality management staff will have limited success developing trust with frontline staff.

[64] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.
[65] VA OIG, *Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia.*
[66] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[67] VHA Directive 1050.01(1).

The ADPCS, acting Deputy ADPCS, and Chief Nurse of Acute Care each informed the OIG in separate interviews that they did not have access to a report of all the events entered into the patient safety reporting system. Since nursing leaders do not have access to all the information, they are unable to track and address systems issues that affect patient safety and prevent recurrence. Additionally, a staff member said there was no process for staff to learn about the results of an event's investigation after submitting a report. The Chief Nurse of Acute Care reported that quality management staff said they restricted access due to privacy issues.[68]

Based on a review comparing institutional disclosures to patient safety events that occurred in the 12 months prior to the inspection, the OIG found facility leaders may have missed opportunities to provide patients with institutional disclosures.[69] When the OIG provided the Risk Manager with examples of patient safety events that may have warranted an institutional disclosure, the manager seemed unfamiliar with the events and confirmed leaders had not conducted disclosures.

VHA policy supports an "ethical obligation to disclose" adverse events sustained during the course of patient care by conducting institutional disclosures, "including cases where the harm may not be obvious, or where there is a potential for harm to occur in the future."[70] If leaders do not disclose adverse events, they may miss opportunities to learn and improve from those events as well as lose trust from patients and staff.[71] The OIG would expect patient safety managers to conduct initial assessments of reported events, notify the Risk Manager, and the Risk Manager to collaborate with facility leaders to determine which events warrant institutional disclosures.

The VISN Director is responsible for ensuring facilities' Quality and Patient Safety Programs comply with the VHA directive, and the VISN Quality Management Officer is an advisor and resource to facility staff.[72] Therefore, the OIG recommends the Under Secretary for Health directs the national VHA Quality and Patient Safety Program staff to review the facility's quality management program and determine whether actions by facility and VISN leaders effectively addressed system issues affecting patient safety, including nursing leaders' lack of access to

[68] "Corresponding with reporters will build important relationships and cultivate safety culture by providing closed-looped communication regarding the patient safety event. This also reassures the reporter they are making a difference by contributing to safer care for patients and staff and will build confidence in the patient safety program." The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

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

[70] VHA Directive 1004.08.

[71] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events* (*2nd ed*.), Institute for Healthcare Improvement White Paper, 2011.

[72] VHA Directive 1050.01(1).

safety event reports, and missed opportunities for institutional disclosures, and takes action as needed.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[73] 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.[74] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[75] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Prior to the OIG's visit, a human resources specialist identified vacancies in 36 primary care positions. Nineteen of these 36 positions, including the chief and two medical directors, had been vacant longer than 12 months.[76] The acting Chief of Primary Care and the ADPCS discussed provider recruitment challenges, including competition with seven local community hospitals. The leaders described using salary adjustments and relocation, recruitment, and retention bonuses as incentives for hiring physicians, nurse practitioners, registered nurses, and licensed practical nurses. To monitor vacancies and timeliness in hiring, the Assistant Chief of Primary Care reported attending a weekly meeting with human resources staff.

The OIG did not make a recommendation because leaders implemented actions to fill vacant positions. However, as described in the Culture section of this report, the facility had an ongoing problem with staff retention, not recruitment. Additionally, one staff member reported fear of reprisal and lack of psychological safety contributed to increased resignations. The OIG

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

[74] 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).

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

[76] Three employees had start dates that resulted in 19 vacant positions open greater than 12 months.

determined that until leaders address these systemic issues, they will have limited success retaining staff in these positions.

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.[77] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[78]

The Senior Principal Facility Coordinator reported 34 out of 39 primary care panels were at or above 100 percent capacity, with 2 of 17 physician panels and 15 of 22 non-physician panels above the facility's 115 percent threshold.[79] During interviews, primary care leaders and staff said they needed more staff to function effectively.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[80] 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 the increased number of tasks, such as responding to clinical alerts (notifications in the electronic health record system) and answering patients' secure messages, affected the efficiency of primary care teams. To help manage walk-in patients, the Chief Nurse of Primary Care reported developing a policy that included having dietitians, social workers, or pharmacists see patients initially, if warranted.

The acting Chief of Primary Care said clinical alert fatigue was a main concern for providers.[81] To decrease the number of clinical alerts, the acting Chief of Primary Care described working with the acting Chief of Health Informatics, acting Chief of Staff, and Director to remove primary care as the default provider group to receive all clinical alerts, and instead alert the ordering providers. The acting Chief of Primary Care also worked with VISN leaders to purchase computer software that would streamline reporting laboratory values, resulting in fewer alerts.

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[77] "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).

[78] VHA Directive 1406(1).

[79] Modeled panel capacity is "the maximum number of patients a PACT [primary aligned care team] is expected to care for," which is currently set at 1,200. "Panel capacity for general PACTs will vary from facility to facility depending on patient characteristics and level of system support." VHA Directive 1406(1).

[80] VHA Handbook 1101.10(2).

[81] Alert fatigue describes how busy clinicians "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

Primary care staff also expressed that the workload could cause providers to miss or delay responding to important clinical alerts, which could affect patient safety. To help manage workload, the acting Chief of Primary Care and Chief Nurse of Primary Care discussed strategies, such as hiring fee-based and gap providers (physicians or nurse practitioners who cover planned or unplanned leave), providing telehealth services, and adding a telehealth registered nurse to cover nursing absences. The acting Deputy Chief of Staff reported educating new providers about using additional support, such as clinical pharmacists, to help manage their diabetic patients. Because facility leaders continued to hire staff and implemented strategies to manage workload, the OIG did not make a recommendation.

The OIG determined primary care leaders were aware of staff concerns and made efforts to address them. However, based on the primary care team interview, the OIG found primary care staff were not aware of the actions leaders had taken. The OIG did not make a recommendation but encourages primary care leaders to communicate frequently and regularly with primary care staff about actions taken to address their concerns.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found that veteran enrollment increased from October 2020 through March 2024. The Chief Nurse of Primary Care reported the PACT Act's implementation had increased enrollment at two community-based outpatient clinics, so the Aiken clinic received an additional primary care team, and a gap provider assisted with walk-in patients at the Athens clinic. The acting Chief of Primary Care stated the PACT Act did not affect veterans' access to care. The OIG reviewed the facility's primary care data over the past two years and found appointment wait times fluctuated between 5 to 8 days for established patients and 5 to 14 days for new ones.

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

Health Care for Homeless Veterans

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

needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[82]

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).[83] 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."[84] According to the national program office, the facility was exempt from the performance measure in FYs 2021 through 2023 because there was a low population of unsheltered veterans in the area.[85] Program staff said they participated in the annual point-in-time count but it might not capture all of the homeless veterans in the area because it occurred in January, when many had temporary shelter because of the cold weather.

A program staff member said staff partner with local agencies, visit shelters, and provide outreach with local law enforcement and homeless continuum of care staff to engage with veterans.[86] Additionally, the Supervisory Social Worker told the OIG that program staff conduct community and street outreach and held Stand Down events in 2023 and 2024 to identify veterans and enroll them in the program.[87] The supervisor said street outreach is somewhat successful, but most referrals to the program were veterans who accessed the homeless team's walk-in clinic.

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

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

[84] 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.

[85] The HCHV program established guidance for the engagement of unsheltered homeless veterans (HCHV5) performance measure to exempt facilities when they would not meet national targets due to low populations of unsheltered veterans. VHA Homeless Programs, *HCHV5: Engagement of Unsheltered Veterans – FY23 Exempted Sites*.

[86] The Continuum of Care Program "is designed to promote a community-wide commitment to the goal of ending homelessness." "Continuum of Care Program," Department of Housing and Urban Development, accessed October 7, 2024, https://www.hud.gov/program_offices/comm_planning/coc.

[87] VHA defines street outreach as "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." Community outreach takes "place in community-based settings such as shelters, meal sites, homeless Veteran Stand Down events, job fairs, resource and referrals centers, and other community outreach events." Stand Downs are one- to three-day events to conduct outreach and engage homeless veterans and present housing opportunities and treatment. Stand Downs include VA and community services to assist veterans. 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).[88] The Supervisory Social Worker said the HCHV1 and HCHV2 measures were not applicable to the facility because they did not have contracted residential services.[89] Program staff shared that community shelters provided housing for veterans in need of emergency placement.

Program staff identified health care, mental health treatment, security deposits, rental assistance, and household items as needs of veterans enrolled in the program. In addition to collaborating with other VA services, staff said they partner with community organizations to meet veterans' needs. Partnerships included Supportive Services for Veteran Families agencies, local not-for-profit organizations, food banks, VSOs, public housing authorities, law enforcement, and emergency shelters.[90]

Program staff mentioned providing dedicated storage at the facility to keep items needed by homeless veterans, including sleeping bags, backpacks, and mattresses, as an opportunity for improvement. Currently, they could not accept donations for these items because no storage was available. The OIG did not make a recommendation but encourages facility leaders to explore options for program staff to store items to give veterans when needed.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[91] 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.[92]

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[88] 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*.

[89] Contracted residential services are community agencies contracted by VA medical facilities that provide residential care to veterans, including therapeutic services and treatment. VHA Directive 1162.04, *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022.

[90] Supportive Services for Veteran Families provides case management to prevent homelessness, find more suitable housing, or rapidly re-house veterans. "Supportive Services for Veteran Families," Department of Veterans Affairs, accessed August 14, 2024, https://www.va.gov/homeless/ssvf.

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

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

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[93] The facility met the performance measure target in FY 2023. Program staff said they educated facility staff, as well as legal, jail, and law enforcement staff about the program to increase referrals.

Meeting Veteran Needs

The Veterans Justice Outreach Coordinator stated individualized treatment plans addressed the clinical and legal needs of veterans enrolled in the program. The coordinator identified substance abuse treatment and medical and mental health services as veterans' primary needs. The coordinator reported to the OIG that veterans' needs were met through coordination with VA and community services. The coordinator said one barrier to meeting veterans' needs was lack of transportation in rural areas, and therefore, a VSO or program staff transported veterans to medical appointments, when needed.

> Veterans Justice Program staff discussed local development of a jail diversion (deflection) program, a partnership in which law enforcement would bring veterans experiencing a mental health emergency to the facility's emergency department for evaluation and treatment instead of arresting the individual.

Figure 9. *Program best practice. Source: OIG interview.*

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."[94] 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.[95]

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

[93] 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*.

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

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

to the facility that are being used by veterans or their families (performance measure HMLS3).[96] The facility did not meet the target from FYs 2021 through 2023. The Supervisory Social Worker reported that during the COVID-19 pandemic, there was a housing shortage, and it was difficult to find landlords willing to accept veterans' vouchers. To address this challenge, program staff focused on outreach and building relationships with landlords to increase their willingness to accept vouchers.

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).[97] The facility exceeded the target from FY 2021 through 2023. The facility attributed success in employing enrolled veterans to the Community Employment Specialist's strong relationships with local employers, as well as the specialist's work with veterans on employment readiness activities, such as resume writing and mock interviews.

Veterans' needs identified by program staff included money management and budgeting, mental health and substance abuse treatment, medication management, and dental services. Program staff used VHA and community resources to meet veterans' needs; however, a staff member identified inadequate public transportation as a barrier. The Supervisory Social Worker stated that although buses serviced the area, better paying jobs were on the outskirts of the bus routes. The Housing Assistant indicated that two senior living communities were in an area with no public transportation, reducing housing options for older veterans who did not have vehicles. The Supervisory Social Worker added the public transportation agency was surveying service needs and asking bus riders about their transportation preferences.

Additionally, program staff said the Freedom's Path apartments, located at the facility's uptown division, had approximately 97 housing units dedicated to veterans with Housing Choice Vouchers but did not accept Housing and Urban Development–Veterans Affairs Supportive

[96] VHA sets the HMLS3 target at the national level each year. The target in FYs 2021 and 2022 was 92 percent or above, and the target in FY 2023 was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2021 Homeless Performance Measures and Metrics*; VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[97] VHA sets the VASH3 target at the national level. For FY 2021, the target was 45 percent or above; for FY 2022, the target was 47 percent; and for FY 2023, the target was 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2021 Homeless Performance Measures and Metrics*; VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*; VHA Homeless Programs, *Technical Manual: FY 2023 Homeless Performance Measures*.

Housing program vouchers.[98] The Supervisory Social Worker explained that VHA did not manage the property or provide case management to veterans living there. According to the Supervisory Social Worker, facility and VISN staff attempted to have some of the Housing Choice Vouchers changed to program vouchers because program vouchers include VA case management services; however, they were unsuccessful due to a change in apartment ownership. The Supervisory Social Worker shared that although the veterans did not have case management services, they assisted them as needed. The OIG did not make a recommendation but encourages facility leaders to take actions to support program voucher acceptance at Freedom's Path apartments.

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.

[98] "The Housing Choice Voucher Program (also known as Section 8) helps low-income families, elderly persons, veterans and disabled individuals afford housing in the private market." Local public housing agencies administer Housing Choice Vouchers. "HCV Applicant and Tenant Resources," Department of Housing and Urban Development, accessed October 7, 2024, https://www.hud.gov/hcv/tenants.

OIG Recommendations and VA Response

Finding: The OIG learned through questionnaires and interviews that staff perceived facility leader's communication as unprofessional, aggressive, hostile, abusive, coercive, and dictatorial.

Recommendation 1

The OIG recommends the Under Secretary for Health evaluates facility leaders for appropriate supervisory behavior and professional communication and takes actions as needed.

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

Under Secretary for Health Comments

The Under Secretary for Health will evaluate facility leaders for appropriate supervisory behavior and professional communication and take necessary actions based on those evaluations, as necessary.

Finding: The OIG identified repeated concerns and findings from a previous OIG report related to leaders' communication issues and unprofessional behavior that affected staff's ability to work in a psychologically safe environment

Recommendation 2

The OIG recommends the Under Secretary for Health determines whether the Veterans Integrated Service Network Director and other Veterans Integrated Service Network leaders were aware of, but did not address, facility leaders' unprofessional behavior and communication, and takes actions as needed.

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

Under Secretary for Health Comments

The Under Secretary for Health will determine whether the Veterans Integrated Service Network (VISN) Director and other VISN leaders took actions to support facility operations and facility leaders with identified cultural challenges and take action, as needed.

Finding: The OIG identified repeated concerns and findings from two previous OIG reports related to supply management issues that impacted the staff's ability to provide safe patient care.

Recommendation 3

The OIG recommends the Under Secretary for Health ensures the Veterans Integrated Service Network and facility directors oversee the inventory management system, resolve medical supply deficiencies, and monitor actions for sustained improvement.

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

Under Secretary for Health Comments

The VISN and facility director will monitor implementation of the inventory management system, ensure resolution of medical supply deficiencies, and monitor quarterly sustained actions for improvement. They will report this information for review to an Under Secretary for Health designee at VHA Central Office.

Finding: The OIG found facility audit results demonstrated an opportunity to improve communication of urgent, noncritical test results, but facility leaders did not have action plans to increase compliance rates.

Recommendation 4

The OIG recommends facility leaders develop action plans to ensure providers communicate test results to patients timely.

__X__ Concur

____ Nonconcur

Target date for completion: December 2025

Director Comments

The facility Chief of Staff has established a process to strengthen the timely communication of test result to patients. Monthly reviews in Ear Nose and Throat, Urology, and Primary Care are conducted to monitor compliance with timely test result communication. Audits will be reported and monitored by the Quality and Patient Safety (QPS) Council for compliance monthly for no less than 6 months, and appropriate action will be taken, as needed.

Finding: The OIG identified concerns with nursing leaders not having access to patient safety event information, and potential missed opportunities for conducting institutional disclosures.

Recommendation 5

The OIG recommends the Under Secretary for Health directs the national VHA Quality and Patient Safety Program staff to review the facility's quality management program and determine whether actions by facility and Veterans Integrated Service Network leaders effectively addressed system issues affecting patient safety, including nursing leaders' lack of access to safety reports, and missed opportunities for institutional disclosures, and takes action as needed.

__X__ Concur

____ Nonconcur

Target date for completion: September 2025

Under Secretary for Health Comments

VHA QPS, in collaboration with the VISN Director, will complete a review of the facility's quality management program to determine whether system issues affecting patient safety, including nursing leaders' lack of access to safety reports, and missed opportunities for institutional disclosures were effectively addressed. The VISN Quality Management Officer and Patient Safety Officer will work collaboratively on the assessment, corrective actions, and ensure access to lessons learned for Patient Safety reports. Progress on these actions will be reported for no less than 6 months in the VISN QPS Committee, and a final report will be presented during a VHA Central Office QPS Council meeting.

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 September 24 through 26, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in March 2022.

[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.

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 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.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: Acting Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: April 11, 2025

From: Acting Under Secretary for Health (10)

Subj: Office of Inspector General (OIG) Draft Report, Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia (VIEWS 12835937)

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

1. Thank you for the opportunity to review and comment on Office of Inspector General (OIG) draft report, Healthcare Facility Inspection of the Department of Veterans Affairs (VA) Augusta Health Care System in Georgia.
2. The Veterans Health Administration concurs with the recommendations and provides the attached action plan for recommendations 1-3 and 5 made to the Under Secretary for Health. The response to recommendation 4 is also included and has been provided by Veterans Integrated Service Network 7 and VA Augusta Health Care System.
3. Comments regarding the contents of this memorandum may be directed to the Government Accountability Office OIG Accountability Liaison Office at vacovha10oicoig@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D., MBA, FACHE

Appendix D: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 11, 2025

From: Director, VA Southeast Network (10N7)

Subj: Office of Inspector General (OIG) Draft Report, Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia

To: Acting Under Secretary of Health (10)

Director, Office of Healthcare Inspections (54HF04)

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

1. Thank you for the opportunity to review the draft report, Healthcare Facility Inspection of the Department of Veterans Affairs (VA) Augusta Health Care System in Georgia. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
2. Since my arrival in July 2021, Veterans Integrated Service Network (VISN) 7 Executive Leadership Team has operated on the principles of the High Reliability Organization (HRO) framework and utilized Commitment Management in our oversight role. VISN 7 has been engaged in efforts to facilitate a just culture, including an HRO/Just Culture Network Director Town Hall focusing on operating in HRO principles, using Change Management principles to drive transformation, and Commitment Management to drive accountability. In addition, there has been contracted support in place to assist with employee engagement and improve organizational culture. Other support and consultation have been provided by the VISN 7 Organizational Health Psychologist. Additionally, VISN 7 Leaders and I have provided consistent support to minimize potential risks to operations and culture resulting from leadership vacancies and transitions, including detailing VISN leaders into unencumbered facility leadership positions and continuously promoting the acquisition of a full complement of the Augusta leadership team. Other oversight actions include trainings on institutional disclosures resulting in increased reporting and completion of annual site visits for Quality Control Reviews, Primary Care, and Quality and Patient Safety.

   I have ensured that appropriate actions and referrals to the Office of Accountability and Whistleblower Protection have been completed. Staff with noted concerns also received appropriate referral information.

3. I concur with recommendation 4 and the facility action plan submitted and commit to supporting the Acting Under Secretary for Health's action plan for the additional recommendations.
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 E: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 10, 2025

From: Executive Director, VA Augusta Health Care System (509)

Subj: Office of Inspector General Draft Report, Healthcare Facility Inspection of the VA Augusta Health Care System in Georgia (12835937)

To: Veterans Integrated Service Network (VISN) 7 Network Director, VA Southeast Network (10N7)

1. Thank you for the opportunity to review the draft report, Healthcare Facility Inspection of the Department of Veterans Affairs (VA) Augusta Health Care System in Georgia. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
2. We at the VA Augusta Health Care System take Veteran care seriously. The supply chain technology faltered in December 2023 and the facility has been actively working with the Vendor and other experts on repairing the system to include enhancing communication processes between the direct care units and Supply Chain Management, adding a communication link on the Augusta home page where all staff can enter a supply item request and receive an immediate response from a Supply Chain Supervisor, and having the Vendor on site to repair the system. Currently 50% of the supply sites are back online and reports of unavailable supplies have greatly diminished. The Augusta leadership team will also embark the organization on internal initiatives to focus on improved communications, individual development, and healthy relationships for the entire organization. Quality Management is a vital part of the organization and works integrally with all members of the VA Augusta team. Augusta leadership has enhanced support of the Quality Management team and the process improvements they provide for the organization. The Patient Safety Managers provide trended data monthly to leaders in the organization. The well attended (average 400 staff) Fireside Chat is a time for leaders and services to share information with all staff. The Fireside Chat approach has received acknowledgment from external stakeholders and adopted by other sites as a promising practice.
3. I concur with recommendation 4 and submit the attached action plan and will actively contribute to the implementation of the Acting Under Secretary for Health's action plan.

(Original signed by:)

Oscar G. Rodriguez
Acting Executive Director

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