US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System in Nashville

Healthcare Facility Inspection	**25-00197-236**	**November 19, 2025**

OUR MISSION

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

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Executive Summary

The Office of Inspector General's (OIG's) mission is to conduct independent oversight of the Department of Veterans Affairs (VA) that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors. 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 Tennessee Valley Healthcare System (facility) from February 11 through 13, 2025.[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 system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. During interviews, executive leaders identified turnover in executive leadership positions as a system shock. Multiple people had served as the Associate Director for Patient Care Services since 2022, and the Associate Director for Operations was permanently hired in 2023. The current executive leaders said a negative culture at the facility stemmed from staff's perceptions of favoritism under previous leaders. In response, leaders increased engagement with frontline staff and communicated with them through meetings and frequent visits to workspaces, including weekend visits to clinics to maximize interactions.

After reviewing the facility's VA All Employee Survey scores, the OIG noted the best places to work and psychological safety scores improved from fiscal years 2022 to 2024.[2] Executive

[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] 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.

leaders said they fostered a more supportive environment. They established employee-driven committees that identified solutions to workplace challenges, as well as innovation competitions for employees to present their ideas.

Patient advocate responses to an OIG questionnaire indicated executive leaders address veterans' concerns.[3] Respondents identified unanswered phone calls as the top concern, and executive leaders discussed plans to address the phone system by increasing the use of online secure messaging. This system would reduce incoming calls and provide a trackable communication method between veterans and clinic staff.[4]

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 OIG inspected the facility's Nashville and Alvin C. York (Murfreesboro) medical centers and found them easy to locate and navigate. They both had ample parking, clean and accessible main entrances, and helpful information desk staff.

The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act of 2022 expanded VA health care and benefits to veterans exposed to toxic substances.[5] The OIG learned that two toxic exposure screening navigators and three additional staff were assigned to assist with the screening process.

The OIG reviewed a prior Joint Commission inspection report that identified issues with preventive maintenance and expired supplies. During this inspection in February 2025, the OIG observed overdue or missing preventive maintenance stickers at the Nashville Emergency Department and Murfreesboro Urgent Care clinic. The OIG also found expired supplies in the Community Living Center, which the Nurse Manager promptly removed. In addition, the OIG noted the facility had two preventive maintenance procedure documents with each listing a different leader as responsible for the program. The OIG made two related recommendations. In response, leaders acted quickly by developing and implementing action plans that addressed the issues and clarified program accountability. Therefore, the OIG closed both recommendations (see OIG Recommendations and VA Responses).

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

[4] "Send and Receive Secure Messages," Department of Veterans Affairs, accessed July 23, 2025, https://www.va.gov/health-care/send-receive-messages/.

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

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 facility had processes to ensure effective communication of test results between ordering providers and patients.

The Chief Nurse of Primary Care explained supervisors review electronic health records during performance evaluations to verify if providers communicated test results to patients and took appropriate actions. The OIG also noted staff used an innovative tool called Qgenda. This tool provides up-to-the-minute contact information for all ordering providers and alternates and makes communicating test results faster.

Additionally, the OIG found that facility leaders and staff had processes to monitor improvement actions. The Patient Safety Manager described communicating with staff to ensure they remain informed about patient safety processes and improvement efforts. Patient safety staff frequently attend service chief meetings to update leaders on patient safety issues, and the Chief Process Improvement Officer for Primary Care discusses patient safety during town halls. Executive leaders signed the VHA Safety Culture Commitment to foster a culture of safety using evidence-based practices and created a video explaining their commitment.[6]

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the PACT Act affected the primary care delivery structure and new patient appointment wait times.[7]

The OIG found there were 52 primary care vacancies. To recruit providers, primary care leaders attended job fairs, worked with physician recruiters, and identified candidates through the nurse practitioner residency training program. The Associate Chief of Staff stated that hiring providers had not been difficult because leaders had previously increased their salaries, which made them competitive with the private sector.

The Patient Centered Management Module Coordinator reported meeting weekly with primary care leaders and administrative staff to review the number of patients assigned to a primary care

[6] "The VHA Safety Culture Commitment serves as a demonstration of VHA's alignment with Culture of Safety principles and practices, emphasizing our focus on the health and safety of our valued Veterans and our dedicated staff members." "Safety Culture Commitment," National Center for Patient Safety, accessed May 27, 2025, https://dvagov.sharepoint.com/Safety-Culture-Commitment.aspx. (This website is not publicly accessible.)

[7] PACT Act.

team.[8] The Associate Chief of Staff for Primary Care emphasized there were not enough primary care teams to accommodate the number of new patients, which had increased by 3.1 percent from the previous year. To address this issue, primary care leaders reported opening a new clinic with three teams at Fort Campbell, but they quickly reached capacity. Additionally, the Chief of Staff said Veterans Integrated Service Network leaders had approved additional rental space in Nashville, Chattanooga, and Clarksville for new primary care teams.[9] The Chief of Staff also discussed plans to build new community-based outpatient clinics in Cookeville, Bowling Green, and Columbia.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. Healthcare for Homeless Veterans staff reported that an increase in outreach personnel helped the program exceed the fiscal year 2024 measure for enrolling homeless veterans. The staff noted that while they engaged with homeless veterans who were ineligible for VA services, they could not be counted in the measure. Staff also described their participation in point-in-time counts, an estimation of the homeless population in communities across the nation, and explained it did not accurately capture the number of homeless veterans.

Staff identified transportation options; affordable, low-barrier housing (when landlords accept residents with prior convictions, arrests, or low credit scores); and supportive housing for older veterans as key challenges for homeless veterans. In the Housing and Urban Development–Veterans Affairs Supportive Housing program, supervisors identified similar challenges. Program Supervisors reported that new veteran-focused housing options in the Nashville area contributed to increased voucher use from fiscal years 2022 to 2024.

The Veterans Justice Program met its goal for enrolling veterans in fiscal years 2023 and 2024. Program staff credited this success to hiring additional staff and receiving support from the national program office. However, program staff identified barriers in reaching incarcerated veterans virtually because VA systems and some jail communication platforms were incompatible. The staff could not identify any actions program leaders took to address this issue, and the OIG encouraged executive leaders to address these information technology barriers.

[8] The Patient Centered Management Module Coordinator manages staff, assigns patients for all teams, and identifies the "set maximum panel capacity." VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025.

[9] 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/.

What the OIG Recommended

The OIG made two recommendations.

1. Facility leaders ensure staff perform preventive maintenance in accordance with manufacturers' guidelines and clearly define staff responsibilities.
2. Executive leaders continue to recruit a permanent chief of biomedical engineering and implement processes to prevent repeat environment of care findings.

VA Comments and OIG Response

The acting Veterans Integrated Network Director and facility Director concurred with our findings and recommendations and provided acceptable improvement plans (see appendixes C and D, and the responses within the body of the report for the full text of the directors' comments). Based on the information provided, the OIG considers recommendations 1 and 2 closed. No further action is required.

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

FACILITY IN CONTEXT

VA Tennessee Valley Healthcare System
Nashville, Tennessee
Level 1a-High Complexity
Davidson County
Hospital Referral Region: Nashville

Description of Community

POPULATION

Female **1,812,110**		Male **1,755,150**
Veteran Female **26,430**		Veteran Male **205,481**

Homeless - State **10,567**
Homeless Veteran - State **549**

MEDIAN INCOME

$49,532

EDUCATION

84% Completed High School
48% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **274**

SUBSTANCE USE

22.9% Driving Deaths Involving Alcohol
15.5% Excessive Drinking
1,298 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	1,325,434
Carpool	148,401
Work at Home	114,539
Walk to Work	24,431
Other Means	20,494
Public Transportation	10,073

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**35 Minutes, 29 Miles**
Specialty Care	**76 Minutes, 71 Miles**
Tertiary Care	**87 Minutes, 83 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **40,931**

Veterans Receiving Telehealth (Facility)	41%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	15%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

33,851

124 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.58 Days

30-DAY READMISSION RATE

11%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
22	39

Health of the Facility

UNIQUE PATIENTS

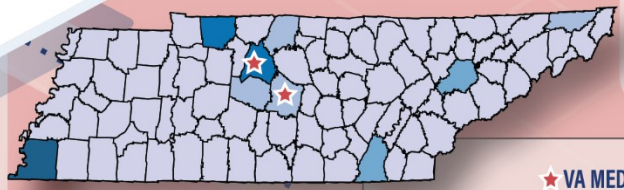
Unique Patients VA and Non-VA Care	116K
Unique Patients VA Care	109K
Unique Patients Non-VA Care	59K

COMMUNITY CARE COSTS

Unique Patient $38,354	Outpatient Visit $3,135
Line Item $1,604	Bed Day of Care $307

STAFF RETENTION

Onboard Employees Stay <1 Yr	13.11%
Facility Total Loss Rate	11.82%
Facility Retire Rate	1.94%
Facility Quit Rate	8.71%
Facility Termination Rate	1.03%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.07% 2.43% 4.79% 7.15% 9.51% 11.86%

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) 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 cyclical review program to help accomplish its mission. Inspection 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 (VA), "VHA's Journey to High Reliability."*

Healthcare Facility Inspection 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]

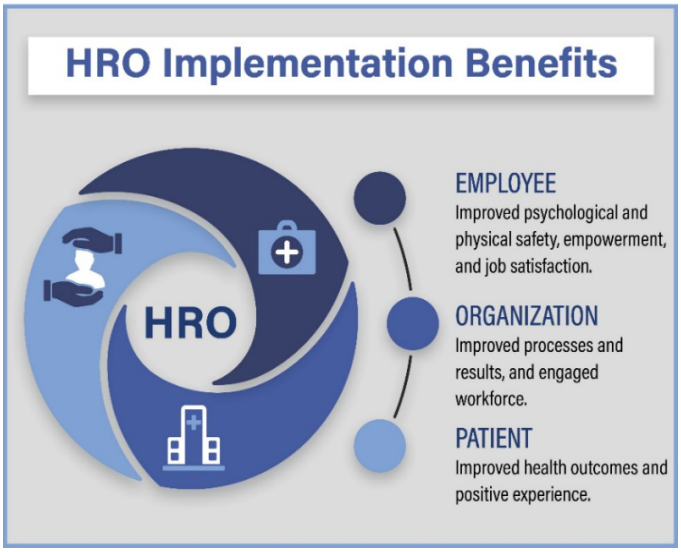


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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 inspectors observed how facility leaders incorporated high reliability principles into their operations.

[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.

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 (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), 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. *Healthcare Facility Inspection'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(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; 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.

According to the Chief of Quality and Patient Safety, the VA Tennessee Valley Healthcare System (facility) consists of the Nashville VA Medical Center and the Alvin C. York VA Medical Center. The Nashville division opened in 1943 as an Army general hospital. The Department of Veterans Affairs acquired it in 1946 and began serving patients on May 1, 1963. The Alvin C. York division in Murfreesboro was built in 1939 and officially opened on January 1, 1940. In 1998, the Murfreesboro and Nashville divisions were integrated into the VA Tennessee Valley Healthcare System. The facility had 377 total operating beds (217 hospital, 144 Community Living Center, and 16 domiciliary), and a fiscal year (FY) 2023 medical care budget of approximately $1.6 billion.[13]

The OIG inspected the facility from February 11 through 13, 2025. The executive leaders consisted of the Executive Director (Director), acting Deputy Executive Director, Chief of Staff, acting Associate Director for Resources, Associate Director for Operations, Associate Director for Patient Care Services (ADPCS), and acting Assistant Director.

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings 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

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed February 26, 2025, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed February 26, 2025, https://www.va.gov/homeless/dchv.asp.

[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.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[16]

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] 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. Executive leaders identified turnover in multiple executive leader positions within the last three years as a system shock. The Chief of Quality and Patient Safety reported that since April 2022, five people served as acting ADPCS until the permanent ADPCS started in April 2024. The chief also noted that the Associate Director for Operations began acting in the role in April 2022 and was hired for the permanent position a year later.

According to the Director, a negative culture previously existed at the facility due to issues such as leaders' lack of visibility and communication, and employees' perceptions of favoritism; this culture primarily affected nursing staff. Other executive leaders described a lack of nursing staff meetings and nursing leaders' visits to workspaces.

The Associate Director for Operations said executive leaders began to make scheduled and unscheduled visits to work areas to interact with frontline staff, gather feedback, identify areas for improvement, and present awards. According to the leaders, these practices improved morale and built trust with staff. The leaders stated that in addition to increased morale, the significant turnover led to positive operational changes. For example, leaders reopened previously closed beds, and allocated staffing to services based on clinical needs. Leaders said the changes resulted in a positive culture shift.

[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.

[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 employees, and shared information.[22] The survey data showed a positive trend for senior leader goal communication, information sharing, and transparency scores in FYs 2022 through 2024. Additionally, OIG questionnaire respondents found executive leader communication as frequent, clear, and useful.

During interviews, executive leaders discussed communication strategies they implemented that led to these positive trends, including visiting clinics every weekend to obtain feedback from employees who worked non-traditional hours and gain a broader perspective of the workforce. Additionally, the Chief of Staff reported holding weekly face-to-face lunch meetings with service leaders to openly discuss issues, if any, as a group. Executive leaders also stated employees could submit questions through a facility website, and leaders posted the questions and answers for all employees to see.

[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.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[23] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[24] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

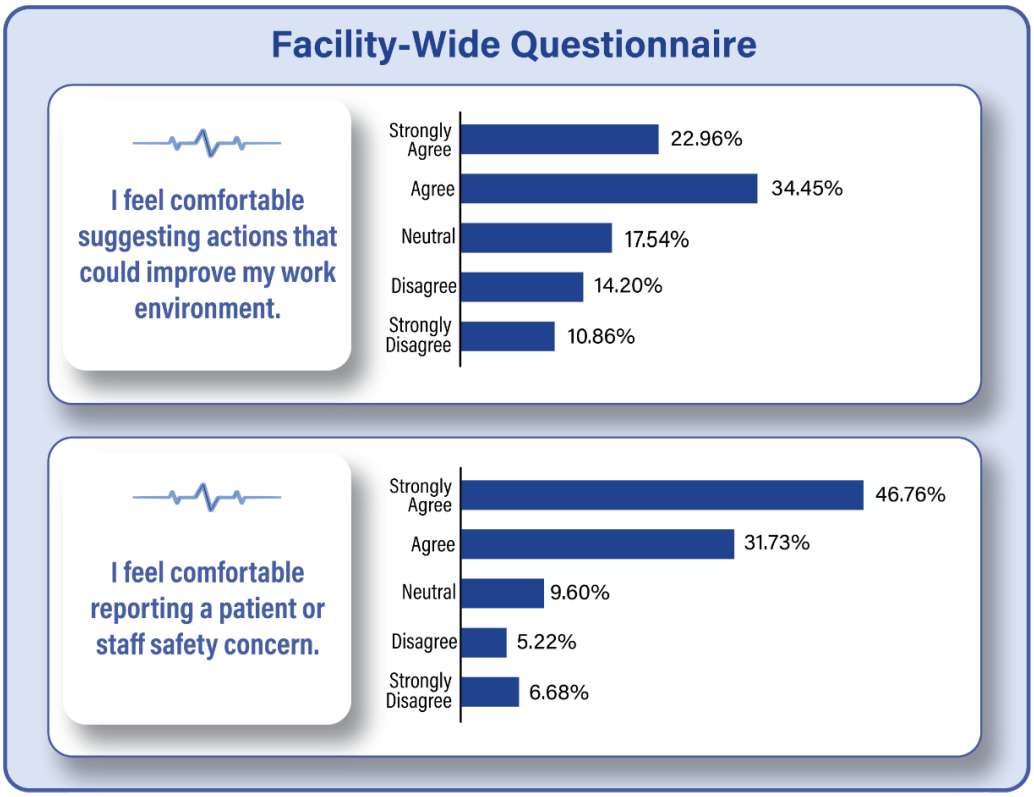


Figure 4. *Employee perceptions of facility culture.*
Source: OIG questionnaire responses.

The OIG reviewed facility All Employee Survey data and found best places to work scores improved from FYs 2022 to 2024. The Director shared that nurses had recommended the facility and recruited others to work there, indicating leaders had fostered an environment where people were eager to join the team.

[23] "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.

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

The Director emphasized it is important to hire the best candidates who are committed to the mission of serving veterans and give employees with poor performance the opportunity to improve and contribute to solutions. Leaders also shared that they attended orientations for new employees and set clear expectations for them.

Through interviews, the OIG learned supervisors participated in training and development programs geared toward enhancing their administrative knowledge and leadership and mentorship skills. Executive leaders said these programs provided supervisors with the necessary skills to take ownership of their work areas. According to the Director, supervisors began to anticipate and proactively address employees' concerns before the issues were brought to executive leaders, showing they were responsive to their employees' needs.

The OIG also reviewed survey questions and leaders' interview responses related to psychological safety. The facility's psychological safety scores increased from FYs 2022 to 2024. The Director said employees trust executive leaders and are comfortable reporting concerns, which helps leaders identify opportunities to improve patient care. The OIG's questionnaire confirmed most respondents feel comfortable reporting patient and employee concerns.

During interviews, executive leaders stated they launched performance improvement committees and innovation competitions for employees to address issues and promote creative solutions. For example, the Chief of Staff shared that Emergency Department employees realized patients experienced long wait times and sometimes left without being seen due to overcrowding. To address this, employees proposed a change to the evaluation process, where a medical provider quickly assesses patients when they arrive in the waiting room to determine the appropriate care path. The new process reduced lengthy wait times.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[25] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

Most respondents to the OIG's patient advocate questionnaire agreed that executive leaders are responsive to veterans' concerns. The advocates cited unanswered phone calls as the most frequent complaint. During interviews, the Director acknowledged this was a known issue, and the Chief of Staff described plans to address it using My HealtheVet (a secure messaging system for veterans to communicate with clinic staff).[26] An increasing number of veterans in primary

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

[26] "Send and Receive Secure Messages," Department of Veterans Affairs, accessed July 23, 2025, https://www.va.gov/health-care/send-receive-messages/.

care had enrolled in My HealtheVet over the last several years, and staff were expanding its use at specialty clinics. Executive leaders said they believe this will reduce the volume of calls, improve timeliness of responses, and allow staff to better track communication. Leaders reported they collaborated with a veterans service organization to establish computer and internet access for veterans who live in rural areas so they can access the My HealtheVet system.[27]

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

Figure 5. *Nashville VA Medical Center. Source: "VA Tennessee Valley Health Care, Locations," Department of Veterans Affairs, accessed July 11, 2025, https://www.va.gov/tennessee-valley-health-care/locations/.*

Figure 6. *Alvin C. York VA Medical Center. Source: "VA Tennessee Valley Health Care, Locations," Department of Veterans Affairs, accessed July 11, 2025, https://www.va.gov/tennessee-valley-health-care/locations/.*

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

[28] VHA Directive 1608(1).

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[29] 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.[30]

Transit and Parking

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

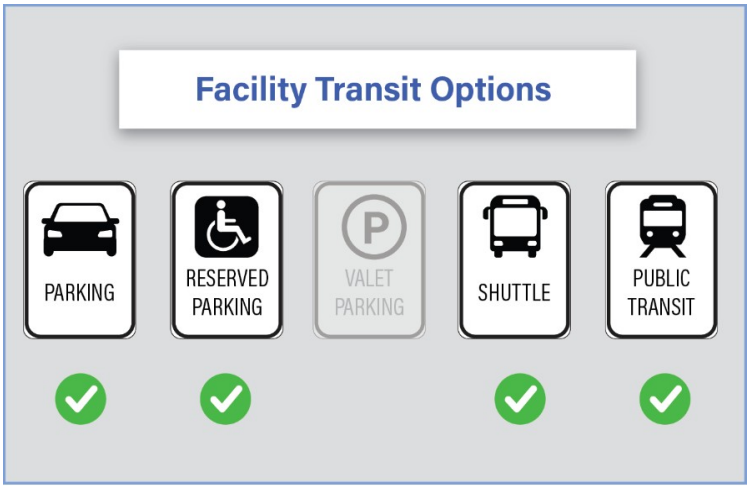


Figure 7. *Transit options for arriving at the facility.*
Source: OIG interviews and analysis of documents.

The OIG inspected the facility's Nashville and Murfreesboro divisions. The OIG easily arrived at each site following directions from the public website. At both locations, the OIG observed signs to direct veterans to parking lots, which offer ample parking, including spaces accessible for those with disabilities. Veterans also have public transit options to reach both divisions.

Main Entrance

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.[31]

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[29] 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.

[30] 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.

[31] 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*.

The OIG observed that both divisions have signs that make the main entrances easy to locate. The main entrances feature designated patient loading zones with canopies to protect veterans from the elements. Both divisions have power-assisted doors that open into clean, well-lit lobbies, with wheelchairs readily available. The entrances also have staffed information desks and comfortable seating for veterans.

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.[32]

The OIG observed signs that guide veterans through the buildings. The signs and directional markers are large, color-coded, and easy to read. Staff at the information desks direct or escort veterans to their desired locations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[33] At both sites, the OIG noted braille on room signs and in elevators. Additionally, information desk staff told the OIG that sign language interpretation services were available, and they could help veterans access this service when needed.

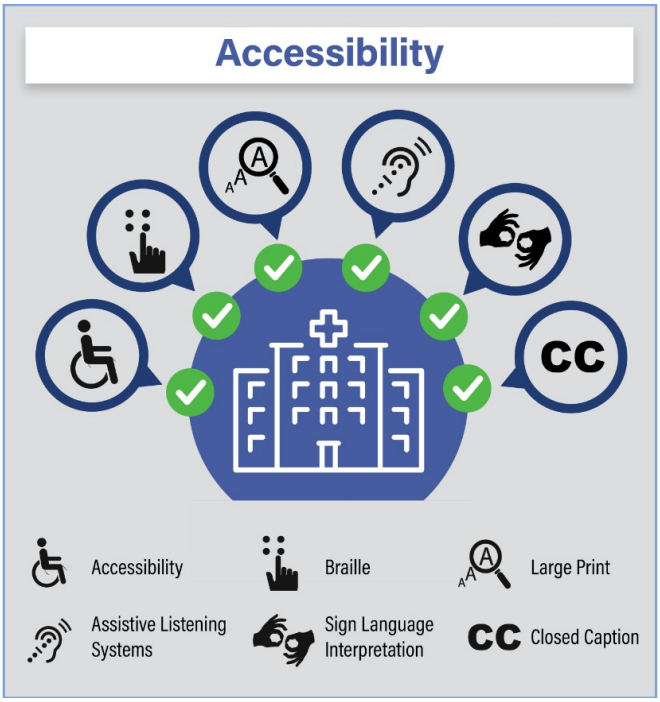

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

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

[33] 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.

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.[34] The OIG learned through a questionnaire that there are two navigators and three additional staff designated to screen veterans for toxic exposure. The OIG reviewed wait time data that showed staff completed screenings within VHA's target of 30 days.[35] During the physical inspection, the OIG observed screening handouts in primary care clinics and at the information desks.

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.[36] The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed a prior Joint Commission inspection report with findings for missing preventive maintenance stickers and expired supplies.[37] During the physical inspection, the OIG found expired supplies in a Community Living Center supply room; the Nurse Manager promptly removed them. Because the finding was limited to one of seven patient care areas inspected and the Nurse Manager removed them, the OIG did not make a recommendation.

The OIG also found noncritical equipment with overdue or missing preventive maintenance stickers in the Nashville Emergency Department and Murfreesboro Urgent Care clinic, indicating staff did not complete maintenance according to manufacturer guidelines. Failure to maintain equipment in accordance with the guidelines can increase the risk of malfunction, disrupt patient care, and pose a safety hazard to patients and staff. The acting Chief of Biomedical Engineering said staff have difficulty tracking equipment used in multiple locations, which contributes to missed or delayed maintenance. The acting chief explained their process is to attempt to locate equipment scheduled for preventive maintenance on three separate occasions. If staff are unable

[34] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

[35] Department of Veterans Affairs, *Toxic Exposure Screening Process*, updated January 2025.

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

[37] The Joint Commission, *Final Accreditation Report: VA Tennessee Valley Healthcare System*, November 3, 2022.

to find the equipment, they perform the maintenance when clinical staff notify them that it is outdated.

The OIG found the facility had two documents covering preventive maintenance procedures, each naming a different individual as responsible for equipment management. For example, one document lists the chief of clinical engineering as responsible for the program; and the other lists the chief of biomedical engineering. The acting Chief of Biomedical Engineering informed the OIG that leaders were aware of the discrepancy and were updating the documents to standardize the title of the responsible individual.

The acting Chief of Biomedical Engineering also said leaders had restructured the engineering department two years prior to the inspection and created a chief of biomedical engineering position. However, after several failed attempts to fill the position, facility leaders requested assistance from Veterans Integrated Service Network (VISN) leaders, who temporarily assigned the VISN Chief of Biomedical Engineering to fill the role.[38] The lack of a permanent chief may have limited program oversight and contributed to missed preventive maintenance.

Overall, the OIG found a lack of oversight in the equipment management program. The OIG recommends facility leaders ensure staff perform preventive maintenance in accordance with manufacturers' guidelines and clearly define staff responsibilities.[39] Because the Joint Commission also identified similar issues with missing preventive maintenance, this remains a recurring issue. The OIG recommends executive leaders continue to recruit a permanent chief of biomedical engineering and implement processes to prevent repeat environment of care findings.[40]

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 physically inspected seven patient care areas at the Nashville and Murfreesboro divisions and found the areas clean. However, the OIG identified a privacy concern at the Nashville division. In a surgical unit, the OIG found an unattended computer with an identification badge and the screen displaying sensitive information, and paperwork face down

[38] 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/.

[39] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

[40] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before the report published.

on the desk; and as such, anyone could access patient information. The OIG found that a staff member had left the computer desk to provide nonemergency care for a patient on the unit.

The OIG would expect staff to secure identification badges, unattended computers, and documents to protect patients' privacy. After learning of the event, executive leaders immediately sent an email to all staff reinforcing responsibilities for protecting sensitive information. Because executive leaders promptly addressed the concern, 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.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42]

The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities. The OIG determined the facility had processes to ensure effective communication of urgent, noncritical test results.

During interviews, the Chief Process Improvement Officer for Primary Care described recent improvements staff made in the radiology department's communication process. Previously, alerts for radiology results were only visible to the diagnostic provider. The chief said radiology staff now add the ordering provider as an additional signer to the clinic note in the electronic health record system. As a result, the system alerts the ordering provider when test results are available, and the alert remains visible until the provider shares the results with the patient.

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

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

According to the chief, this new process helped reinforce providers' accountability for communicating test results.

The Chief Nurse of Primary Care shared that as part of primary care providers' Ongoing Professional Practice Evaluations, supervisors audit electronic health records to ensure providers communicated test results to patients in a timely manner and followed up, as appropriate.[43] The Associate Chief of Staff for Primary Care added that when supervisors identify concerns with communication, they initiate a Focused Professional Practice Evaluation for cause.[44]

Additionally, the OIG noted an innovative tool staff used to support timely communication of test results, known as Qgenda. The Associate Chief Nurse for Health Informatics described it as a facility-wide on-call schedule that staff access through an internal website. The tool lists up-to-the-minute contact information, including alternate points of contact, for providers in all services. Leaders launched Qgenda in June 2024. In February 2025, it had 30 to 40 schedules and covered all the clinical services. The Interim Chief of Radiology stated the tool made contacting providers to communicate test results easier and faster.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[45] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained. The OIG reviewed a previously published OIG report and noted no open recommendations.[46]

The OIG found that executive leaders and staff used various organized groups and tracking mechanisms to monitor improvement actions. The Patient Safety Manager and the Management Analyst for Quality and Patient Safety reported the Quality and Patient Safety Council monitored overdue improvement actions, while the Organizational Performance Improvement Committee addressed barriers to improvement. The Chief of Clinical Operations also mentioned that the

[43] An Ongoing Professional Practice Evaluation is "the ongoing monitoring or privileged [licensed independent providers] to identify clinical practice trends that may impact the quality and safety of care." VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023.

[44] A Focused Professional Practice Evaluation for cause "is a time-limited period during which the clinical service chief assesses the health care LIP's [licensed independent practitioner's] performance to determine if any action should be taken on the LIP's privileges after a clinical concern has been triggered." VHA Directive 1100.21(1).

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

[46] VA OIG, *Comprehensive Healthcare Inspection of the Tennessee Valley Healthcare System in Nashville*, Report No. 21-03312-114, May 16, 2023.

Quality and Patient Safety Council tracked actions until staff had sustained improvement for at least six months.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[47] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[48] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Patient Safety Manager discussed reviewing patient safety reports as the primary mechanism for determining trends in safety issues and identifying opportunities for improvement. The manager described using two approaches to ensure staff remain informed about patient safety processes and improvement efforts: providing direct follow-up through the patient safety event reporting system and conducting unit-based debriefs in which patient safety staff meet with other facility staff to share lessons learned. The manager emphasized that sharing lessons learned is critical because failing to do so can increase the likelihood of repeating errors.

Executive leaders also played an active role in reinforcing patient safety priorities. The Nursing Supervisor for Quality and Patient Safety reported that executive leaders recently signed the VHA Safety Culture Commitment, a nationwide effort involving evidence-based practices that leaders can implement to foster a culture of safety within their facilities.[49] Executive leaders also created a video explaining the commitment and shared it with all staff.

Additionally, the Quality and Patient Safety supervisor said executive leaders presented awards to employees who helped prevent patient safety incidents, demonstrating direct engagement in patient safety initiatives. The Patient Safety Manager explained that patient safety staff frequently attend service chief meetings, where they update executive leaders on patient safety trends and barriers to improvement. The Nursing Supervisor for Quality and Patient Safety said the Chief Process Improvement Officer for Primary Care also discusses patient safety issues during the Chief of Staff's town halls in which staff engage in conversations while having lunch.

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

[48] VHA Directive 1050.01(1).

[49] "The VHA Safety Culture Commitment serves as a demonstration of VHA's alignment with Culture of Safety principles and practices, emphasizing our focus on the health and safety of our valued Veterans and our dedicated staff members." "Safety Culture Commitment," National Center for Patient Safety, accessed July 25, 2025, https://dvagov.sharepoint.com/Safety-Culture-Commitment.aspx. (This website is not publicly accessible.)

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[50] 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.[51] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[52] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG reviewed documents provided by facility staff showing there were 52 vacant primary care positions: 13 provider, 8 registered nurse, 11 licensed practical nurse, and 20 medical support assistant positions. The Chief, Business Office and the Associate Chief of Staff for Primary Care updated the OIG on the medical support assistant positions, explaining there are currently 6 vacancies, but applicants had official start dates to fill 4 of them.[53]

Primary care leaders acknowledged ongoing challenges in hiring and retaining medical support assistants due to the low salary in an area with a high cost of living. The Chief of Staff and Chief, Business Office said they offered retention bonuses and special salary rates to attract and keep these employees.

The Associate Chief of Staff for Primary Care told the OIG that vacancies in provider positions resulted from them transferring to other VHA facilities, resigning, or relocating to move closer to family. Primary care leaders said they had a variety of recruitment strategies, including attending job fairs, working with two physician recruiters, and identifying potential candidates from the facility's nurse practitioner residency training program. Leaders also highlighted a retention

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

[51] 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).

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

[53] After the on-site inspection, the Associate Chief of Staff for Primary Care reported they were actively recruiting 5 providers and had selected 4 applicants. The Chief Nurse of Primary Care stated there were applicants with start dates for all 8 registered nurse positions. The chief also reported they had 6 licensed practical nurse applicants with start dates and had offered a position to one more, with 4 remaining vacancies.

bonus they offered a few years ago and a salary increase over the last several years, which made them competitive with the private sector. As a result, the associate chief reported no difficulties in hiring providers.

Primary care leaders reported that most nurse and provider vacancies occurred when staff transferred to newly established teams, moved to other VA facilities, or left for personal reasons. The ADPCS reported attending career fairs and visiting various schools to recruit nurses. Leaders also offered incentives such as salary adjustments based on local living costs to retain nurses. The ADPCS emphasized that nurse turnover has remained very low.

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

The Chief of Staff reported the facility's enrollment had increased 3.1 percent from the previous year and attributed this increase to soldiers leaving active duty from the Fort Campbell Army base, as well as veterans moving into the area from the Northeast and Midwest parts of the country. The Patient Centered Management Module Coordinator described meeting weekly with primary care leaders and administrative staff to review panel sizes as enrollment increased.[56]

However, the Associate Chief of Staff for Primary Care emphasized they did not have enough primary care teams to keep up with the growing number of new patients. To address this issue, the Chief of Staff and associate chief explained that leaders opened a new clinic with three primary care teams at Fort Campbell in February 2024, but the panels quickly reached capacity. The Chief of Staff further shared plans to build new clinics to accommodate more patients in the Cookeville, Bowling Green, and Columbia areas to replace existing clinics in those locations. Bowling Green's target opening date is February 2028, and they had not yet determined dates for the other two. Primary care leaders also reported that VISN leaders had approved additional rental space in Nashville, Chattanooga, and Clarksville, to accommodate new teams and expected that Clarksville would open in four to six months and accommodate four primary care teams.

[54] "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).

[55] VHA Directive 1406(2).

[56] The Patient Centered Management Module Coordinator manages staff, assigns patients for all teams, and identifies the "set maximum panel capacity." VHA Directive 1406(2).

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[57] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

Primary care staff stated they value primary care leaders' frequent, open communication and responsiveness to their concerns. The Chief Process Improvement Officer for Primary Care highlighted an initiative in which patients complete pre-visit health questionnaires electronically, so providers spend more time on clinical care and less on other tasks. According to the Chief Nurse of Primary Care and the ADPCS, it also saves nurses time during each visit.

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 enrollment increased from FY 2022 through 2024. However, as previously discussed, the Chief of Staff attributed the increase from the previous year to soldiers leaving active duty nearby and other veterans relocating to the area.

Wait times for primary care appointments ranged from 3 to 4 days for established patients in FY 2024, while wait times for new patients fluctuated between 30 and 36 days. The Chief of Staff told the OIG that Saturday clinics are available twice a month for new patients to increase their access to care. The Associate Chief of Staff for Primary Care added that staff also refer patients to community care if necessary.[58]

According to the associate chief, the PACT Act's implementation initially increased workload because of the toxic exposure screening requirements. However, the associate chief and primary care staff said they had incorporated the screenings into appointments scheduled for other clinical issues, so they no longer affected their workload.

[57] VHA Handbook 1101.10(2).

[58] "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "VA Community Care," Department of Veterans Affairs, accessed July 24, 2025, https://www.va.gov/communitycare.

VETERAN-CENTERED SAFETY NET

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice 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.[59]

During a point-in-time count, HCHV staff identified a homeless veteran who was unaware of available VA benefits. Staff obtained proof of their veteran status the same day, and the veteran immediately accessed housing in a hotel. In less than two days, the veteran engaged with homeless program services, including Housing and Urban Development–Veterans Affairs Supportive Housing.

Figure 9. *Success story.*
Source: OIG interview.

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).[60] 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."[61] The facility improved performance for the measure since FY 2022, and exceeded the target in FY 2024. During an interview, the Specialty Program Supervisor attributed meeting the target to several factors: an increase in outreach staff from one to four, greater presence in the community to identify homeless veterans; enhanced oversight through the addition of more program supervisors; and collaboration with a

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

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

[61] 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.

recently established city government homeless office in Nashville to better coordinate between agencies and organizations that conduct street outreach.[62]

However, the supervisor also stated the measure did not accurately reflect the extent of the program staff's outreach and engagement efforts with unsheltered veterans. Many veterans they encountered were ineligible for VA health care, which meant they were not included in the measure. Program staff added that some veterans chose not to complete an assessment, while others were unable to due to untreated mental health issues. The supervisor shared that when veterans are unable to complete an assessment or decline to, staff remain available through regular visits to encampments and other areas to connect them to VA or community-based healthcare and housing services.

Figure 10. *Best practice for veteran engagement.*
Source: OIG interview.

The Director of Mental Health Recovery Services and the Homeless Program Manager reported that both HCHV staff and facility executive leaders participated in the point-in-time count. While acknowledging the count helped gain federal funding for community organizations to address homelessness, and it was an important tool for counting and engaging with veterans, staff noted some shortcomings. For example, volunteers did not count homeless individuals known to live in encampments but who were absent during their visits. Despite this barrier, the program manager provided information showing a 25 percent reduction in Tennessee's homeless veterans in the 2024 point-in-time count compared to the 2023 count.

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).[63] Program staff told the OIG the two measures were not applicable to the facility, because they did not have contracted

[62] The office's mission is "leading Nashville's efforts to end homelessness through innovation, community collaboration and compassion." "Office of Homeless Services," Metropolitan Government of Nashville and Davidson County, accessed March 5, 2025, https://www.nashville.gov/departments/office-homeless-services.

[63] 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*.

residential services.[64] They instead used other transitional housing options, including emergency housing, that were available for veterans.

The staff identified some challenges in supporting veterans in the program, such as finding affordable, low-barrier housing (where landlords accept veterans with histories of prior evictions, arrests, substance abuse, or low credit scores). They also emphasized the need for housing options that support aging veterans with additional healthcare requirements, as well as access to medical care, mental health services, substance abuse treatment, employment support, furniture, and cell phones. The Specialty Program Supervisor said collaboration with facility social workers and mental health providers is important to meet these needs.

Staff cited limited transportation options in more rural areas as a barrier to veterans attending scheduled appointments. To address this issue, staff provided transportation or coordinated with veterans service organizations or the transitional housing provider. The OIG also learned that a VA shuttle provided service between the facility and local transitional housing programs.

The Director of Mental Health Recovery Services and the HCHV Coordinated Entry Specialist explained they knew the program made a difference for veterans, not just through the performance measures, but also from veterans' feedback that described the positive impact the homeless programs made in their lives.

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."[65] 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.[66]

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

[64] 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(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

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

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

to the facility that are being used by veterans or their families (performance measure HMLS3).[67] The facility did not meet the target in FYs 2022 through 2024, but showed a steady improvement each year.

A program supervisor said the lack of affordable housing and limited options for veterans with barriers, such as prior evictions, criminal convictions, or active substance abuse in rural areas were contributing factors to not meeting the target. The supervisors attributed their improving performance, in part, to the development of two housing properties that accepted vouchers, which increased the housing supply. One supervisor also credited improvements to hiring two additional supervisors in FY 2023. These supervisors helped staff manage veterans' complex needs that could otherwise lead to them becoming homeless. Some community agencies with VA grants offered incentives, such as twice the normal deposit amount, to landlords willing to rent to veterans with barriers.

HCHV outreach staff identified a veteran with limited social support and no prior engagement with VA health care, who had lived in a tent in the woods for 10 years. The veteran was apprehensive about pursuing permanent housing, but after building rapport with staff, the veteran accessed VA primary care and received needed medical procedures. Over time, the veteran engaged with the Housing and Urban Development–Veterans Affairs Supportive Housing program. The veteran's program case manager worked with a landlord to find an apartment with a view of the woods since the veteran reported enjoying nature while unsheltered. After achieving permanent housing, the veteran expanded their social network, befriending a neighbor and fellow veteran.

Figure 11. *Success story. Source: OIG questionnaire.*

Staff discussed limited housing for veterans who required additional support, particularly older veterans with decreased independence. Program supervisors said they help them find other living arrangements, such as living with a roommate, a live-in caregiver, in a group home, a VA community living center, or with family.

Additionally, the supervisors described a no-wrong-door approach to program referrals.[68] Through this approach, staff identify veterans through the facility's homeless walk-in clinic, outreach at encampments and homeless shelters, community agencies, veterans service organizations, and facility providers. One supervisor told the OIG there were no barriers to identifying veterans and enrolling them in the program, although there were times when demand for program services exceeded available VA staff resources. To address demand, program staff prioritized veterans based on need and referred veterans to community housing programs for additional assistance.

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

[68] VHA created coordinated systems to ensure there is "no wrong door" for any homeless veteran seeking services. VA Office of Public Affairs, Media Relations, "VA Programs for Homeless Veterans" (fact sheet), January 2018.

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).[69] The facility surpassed the measure in FYs 2022 through 2024. A program supervisor credited this success to collaboration between program staff and facility employment specialists who connected veterans with available employment resources.

Program supervisors shared that veterans in the program had needs similar to those in the HCHV program, and included community integration, food security, budgeting assistance, and driver's license re-instatement. They explained that staff assess veterans' individual barriers to permanent housing, such as a criminal background, eviction history, or substance use. After staff identify veterans' needs, they develop an individualized housing plan to review with veterans and refer them to VA and community services.

Staff engage with landlords to accept veterans with various needs as tenants. Program supervisors discussed their *One Team* approach, integrating the facility's various programs and community partners, to serve veterans better by removing barriers and silos.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[70] 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.[71]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[72] The facility exceeded the target in FYs 2023 and 2024. Program staff attributed their improved performance to hiring an additional staff member and veterans

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

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

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

[72] 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*.

treatment court.[73] Program staff agreed that outreach and education positively affected veterans. For example, they trained social workers at Fort Campbell on the program, which led to additional referrals for service members transitioning out of the Army who were involved in the justice system.

The Health Care for Re-Entry Veterans Specialist discussed success in using virtual technology to meet with veterans at local prisons. However, other program staff reported barriers in virtually accessing some jails due to incompatibility with VA information technology security restrictions. An outreach specialist shared that homeless program leaders were aware of the challenges in accessing these jails' virtual platforms but was uncertain about what steps they had taken to resolve the issue. The OIG encouraged executive leaders to address information technology barriers affecting outreach to veterans in jails.

The Veterans Justice Program Peer Support Specialist highlighted the program's positive impact on the community through veterans treatment court graduations. The graduates demonstrate behavioral growth during these 12- to 18-month programs, resulting in positive changes for them and their families, sometimes including reunifications. One outreach staff member said veterans read essays at graduation describing their personal experience, and some said they feel the program saved their lives. Often, community partners and elected officials attend the ceremonies to show support.

Figure 12. *Program impact. Source: OIG interview.*

Meeting Veteran Needs

Veterans Justice Program staff told the OIG they use comprehensive assessments to determine veterans' needs. The staff identified similar veteran needs as noted in discussions about other homeless programs. According to the outreach team lead, staff connect veterans to services and treatment either within the facility or through community providers. Facility services include the residential treatment program, addiction therapy program, and mental health services. An outreach specialist explained that veterans service organizations may assist veterans in treatment courts to submit benefit claims, which improve veterans' access to VA services and income.

[73] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to preventive maintenance and repeat environment of care findings. In response, leaders promptly developed and implemented action plans that effectively addressed the issues, and therefore, the OIG closed both recommendations (see OIG Recommendations and VA Responses). 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.

OIG Recommendations and VA Responses

Recommendation 1

Facility leaders ensure staff perform preventive maintenance in accordance with manufacturers' guidelines and clearly define staff responsibilities.

_X_ Concur

____ Nonconcur

Target date for completion: September 1, 2025

Director Comments

To ensure preventive maintenance (PM) is completed in accordance with manufacturers' guidelines and staff responsibilities are clearly defined the Associate Director for Operations and the acting Associate Director for Resources will facilitate the update of the Medical Equipment Management Plan (MEMP) and the Equipment Management Program Medical Center Policy (MCP). The updated documents will clearly outline staff responsibilities, and describe the PM process, and eliminate any redundant or vague information. These updated documents will be published on the Tennessee Valley Healthcare System (TVHS) internal SharePoint page, making them accessible to all employees. Additionally, Biomedical Engineering staff will participate in weekly Environment of Care rounds, conducting spot checks to ensure medical equipment has up-to-date PM stickers, indicating that preventive maintenance has been performed.

The Chief of Biomedical Engineering or designee will report compliance rates for both high-risk and non-high-risk medical equipment PM to the Environment of Care Committee (EOC-C) monthly. Reporting will continue until an average compliance rate of 90% or higher is sustained for a period of six months. Compliance will be measured by comparing the number of pieces of medical equipment for which PM was completed (numerator) to the total number of pieces of medical equipment requiring PM (denominator). The monthly compliance rate has been met February 2025 through July 2025. The facility requests closure of this item.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

Executive leaders continue to recruit a permanent chief of biomedical engineering and implement processes to prevent repeat environment of care findings.

_X_ Concur

____ Nonconcur

Target date for completion: September 1, 2025

Director Comments

The Associate Director for Resources recruited a permanent Chief of Biomedical Engineering who began employment on April 21st, 2025.

The facility has established and consistently applies comprehensive processes designed to prevent repeat Environment of Care (EOC) findings. In full alignment with VHA Directive 1608(1), we conduct multidisciplinary rounding across our two campuses and 21 CBOCs, visiting every clinical and non-clinical area twice annually. All data collected during these rounds is tracked using the Performance Logic platform, which facilitates real-time documentation, deficiency identification, and trend analysis. Each month, the Environment of Care Committee (EOC-C), chaired by the Associate Director for Resources, reviews performance trends, corrective actions, and any outstanding issues identified in Performance Logic. Additionally, the committee reviews the EOC dashboard monthly, which tracks high hazard EOC trends, the medical equipment management program, and specific EOC focus areas. The EOC-C not only holds accountability for addressing findings promptly but also escalates systemic concerns and trends to the Healthcare Delivery Council monthly, ensuring executive oversight and continuous quality improvement.

In February 2025, the Tennessee Valley Healthcare System (TVHS) implemented an enhanced version of the Joint Commission Accreditation Manager Plus (AMP) tracer tool. Tracers created were tailored specifically to TVHS, which assist in tracking facility-specific EOC trends. These tracers support continuous evaluation of trends, accrediting body standards, and internal and external survey data. To further ensure facility awareness of trends, executive leadership oversight and multidisciplinary collaboration, environment of care tracer trends are reviewed quarterly in the EOC-C.

Compliance will be considered after six consecutive months of EOC-C meeting minutes reflecting the discussion of environmental rounds and repeat service findings as a standing agenda item. Compliance has been met March 2025 through August 2025. The facility requests closure of this item.

OIG Comments

The OIG considers this recommendation closed.

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. 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from February 11 through 13, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2021, through September 30, 2024.

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 15, 2025

From: Director, VA MidSouth Healthcare Network (10N9)

Subj: Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System in Nashville

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

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

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System in Nashville. I concur with the action plans submitted.
2. We thank the OIG for the opportunity to review and respond to the Draft Report: Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System in Nashville.

(Original signed by:)

Anthony M. Stazzone, MD, MBA, FACP
Acting Network Director, VISN 9

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2025

From: Director, VA Tennessee Valley Healthcare System (626)

Subj: Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System in Nashville

To: Director, VA MidSouth Healthcare Network (10N9)

1. Thank you for the opportunity to review and respond to the draft report of the Healthcare Facility Inspection of the VA Tennessee Valley Healthcare System as part of a continuing process to improve the care of our Veterans. Continuous process improvement is at the core of the VA's mission to provide the highest quality care to Veterans. By constantly examining and refining our practices, we can ensure that patient safety remains our top priority. This commitment to excellence not only enhances the care we deliver but also upholds the trust that Veterans place in us every day. Thank you for allowing us the opportunity to advance this vital mission.
2. I have reviewed the report and concur with both recommendations. I respectfully request the closure of recommendations one and two, as we have successfully completed the necessary corrective actions. Attached, you will find our responses and supporting documentation.
3. Comments regarding the content of this memorandum may be directed to the Chief of Quality and Patient Safety.

(Original signed by:)

Daniel L. Dücker, MSS, M.Ed.
Executive Director

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Pursuant to Pub. L. No. 117-263 § 5274, codified at 5 U.S.C. § 405(g)(6), nongovernmental organizations, and business entities identified in this report have the opportunity to submit a written response for the purpose of clarifying or providing additional context to any specific reference to the organization or entity. Comments received consistent with the statute will be posted on the summary page for this report on the VA OIG website.