US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Suicide Prevention Program Staff Duties at the Atlanta VA Health Care System in Decatur, Georgia

Healthcare Inspection | **26-00120-12** | **November 10, 2026**



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Executive Summary

The VA Office of Inspector General (OIG) did not substantiate an allegation that the assignment of additional psychotherapy duties to suicide prevention program clinical staff at the Atlanta VA Healthcare System (system) in Decatur, Georgia, affected their ability to fulfill program responsibilities. However, the OIG determined that 5 of the 18 staff members were not authorized through their scope of practice to provide psychotherapy or other advanced practice procedures (mental health assessments and diagnosis) to patients at the system.

Scope and Objective

The OIG opened a healthcare inspection to review allegations related to whether suicide prevention program clinical staff met suicide prevention program requirements with additional assignments and whether staff had the licensing, credentialing and privileging or scope of practice, and training to provide the requested psychotherapy. While inspecting the system, the OIG identified an additional concern related to licensed clinical social workers' ability to independently practice.

The OIG initiated the inspection on December 1, 2025; conducted virtual interviews from December 8, 2025, through February 12, 2026; and continued off-site inspection activities, which included corresponding with system leaders, through May 12, 2026.

Key Findings

Psychotherapy Assignment

The OIG did not substantiate that suicide prevention program clinical staff's ability to meet suicide prevention program requirements was limited by the assignment of additional psychotherapy duties. The Veterans Integrated Service Network suicide prevention program manager and system mental health and suicide prevention program leaders did not report that suicide prevention program requirements were affected by the additional psychotherapy assignments. The OIG reviewed two key suicide prevention program metrics and found that neither was negatively affected.

Licensure, Position, and Scope of Practice

The OIG determined that suicide prevention program clinical staff possessed the required licensure (licensed clinical social worker) and were in a position (senior social worker) and clinical assignment (suicide prevention program) in which providing psychotherapy services was an expected responsibility. However, five staff were not authorized by their scope of practice to provide psychotherapy or other advanced practice procedures; this finding likely applies to a larger number of system social workers. A scope of practice defines the nature of a provider's

practice, such as the type of assessments, interventions, and diagnoses the provider is permitted to perform at a facility.[1] Social workers must practice within their scope of practice, privileges, and professional licensure in all care settings.

Licensed Independent Practitioners

VA Handbook 5005/120, *Staffing*, specifies "persons hired or reassigned to social worker positions … in VHA [Veterans Health Administration] must be licensed or certified by a state to independently practice social work …."[2] The OIG found that when recredentialing social workers through the medical staff structure, system leaders blended the scope of practice and privileging processes. By blending these processes, system leaders limited social workers' ability to practice independently.

Impact on Veterans

Suicide prevention is the Veterans Health Administration's (VHA's) top clinical priority.[3] Suicide prevention coordinators are clinical staff who serve as subject matter experts on veteran suicide and are responsible for training, outreach, consultation, program administration, tracking and reporting, and providing direct support and case management to patients.[4] The OIG did not find the additional psychotherapy assignment limited staff's ability to meet suicide prevention program requirements related to patients who may be at risk for suicide.

The system's suicide prevention program clinical staff routinely provide advanced practice procedures, such as psychotherapy and mental health assessments, to patients as part of their job responsibilities; however, the OIG found five staff were not authorized through their scope of practice to provide these services.

Further, the OIG found that system leaders inadvertently limited social workers' ability to practice independently; when there are fewer independent practitioners available to provide care, patients' access to timely mental health services could be negatively affected.

Key Recommendations and Next Steps

The OIG made three recommendations to the System Director related to scopes of practice and identifying social workers as licensed independent practitioners.

[1] VHA Directive 1110.02, *Social Work Professional Practice,* August 16, 2024.

[2] VA Handbook 5005/120, *Staffing*, September 10, 2019.

[3] VHA, *Long-Range Plan FY 2022–2025, n.d.*, https://www.va.gov/HEALTH/docs/FY-2022-2025-VHA-Long-Range-Plan.pdf.

[4] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide,* December 2022.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

VA Comments and OIG Response

The Veterans Integrated Service Network and System Directors concurred with the recommendations and will consult with VHA national program offices in modifying scopes of practice, amending medical staff bylaws, and ensuring social workers are identified as licensed independent practitioners (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.



DAVID C. KRULAK, MD, MPH, MBA
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Abbreviations

OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations that suicide prevention program clinical staff at the Atlanta VA Health Care System (system) in Decatur, Georgia, were required to provide psychotherapy to general mental health patients despite staff's concerns the assignment would take time away from critical suicide prevention responsibilities. The OIG initiated the inspection on December 1, 2025; conducted virtual interviews from December 8, 2025, through February 12, 2026; and continued off-site inspection activities through May 12, 2026.

Background

The system, part of Veterans Integrated Service Network (VISN) 7 at the time of the inspection and currently part of VISN 2, includes the Joseph Maxwell Cleland Atlanta VA Medical Center, a level 1a, high complexity medical center; 14 community-based outpatient clinics; and four outpatient service clinics.[5] The system offers primary care, emergency medicine, and specialty services including mental health, physical medicine and rehabilitation, neurology, and extended care. Mental health services are available at every system location where primary care is provided.

Suicide Prevention Program

Suicide prevention is the Veterans Health Administration's (VHA's) top clinical priority.[6] In 2007, the Joshua Omvig Veterans Suicide Prevention Act directed the Secretary of VA to develop a "comprehensive program" to reduce veteran suicide and designate a suicide prevention counselor at each VA facility to carry out program requirements.[7] In response, VHA established the suicide prevention program. VHA Directive 1160.07, *Suicide Prevention Program*, outlines services to include outreach, education, partnerships, and clinical assessment and interventions.[8]

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[5] In December 2025, VA announced plans to reorganize the management structure of the Veterans Health Administration. On May 1, 2026, the Under Secretary for Health announced the consolidation of the Veterans Integrated Service Networks (VISNs) from 18 networks to 5. On July 15, 2026, the Acting Under Secretary for Health announced that the new VISNs had assumed initial operational responsibilities. VISN references in this report reflect the organizational structure in place at the time of the OIG's review. Any recommendations addressed to a VISN director under the former structure apply to the individuals serving in the equivalent leadership roles in the current VISN structure. For more information on this initiative, visit https://digital.va.gov/rise/; VHA Office of Productivity, Efficiency, and Staffing, "Data Definitions VHA Facility Complexity Model," October 1, 2023. VHA facilities are classified at levels (from most complex to least complex) 1a, 1b, 1c, 2, or 3.

[6] VHA, *Long-Range Plan FY 2022-2025*, n.d., https://www.va.gov/HEALTH/docs/FY-2022-2025-VHA-Long-Range-Plan.pdf.

[7] Joshua Omvig Veterans Suicide Prevention Act, Public L. 110-110, 121 Stat. 1031, November 5, 2007.

[8] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

According to the VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide,* suicide prevention coordinators are clinical staff who serve as subject matter experts on veteran suicide and are responsible for training, outreach, consultation, program administration, tracking and reporting, and providing direct support and case management to patients—including those who are at high risk for suicide.[9] If a facility designates a lead, the facility lead suicide prevention coordinator is expected to ensure that all suicide prevention program clinical staff are meeting requirements outlined in policy.[10]

Allegation and Concerns

The OIG received an anonymous complaint alleging that system mental health leaders required suicide prevention program clinical staff to provide psychotherapy to general mental health patients. The complainant alleged mental health leaders initiated this change despite suicide prevention program clinical staff's concerns regarding taking time away from critical suicide prevention responsibilities and lacking the training needed to provide quality mental health treatment. The complaint did not include allegations of patient harm.

The OIG opened a hotline inspection on December 1, 2025, to review whether suicide prevention program clinical staff were limited by the assignment of additional psychotherapy duties in meeting suicide prevention program requirements and had the licensing, credentialing and privileging or scope of practice, and training to provide the requested psychotherapy. During the inspection, the OIG identified a concern related to licensed clinical social workers' ability to independently practice through the system's medical staff bylaws.

Scope and Methodology

The OIG initiated the inspection on December 1, 2025, conducted virtual interviews from December 8, 2025, through February 12, 2026, and continued off-site inspection activities through May 12, 2026.

The OIG reviewed relevant VA, VHA, and system policies, procedures, and committee meeting minutes related to staffing, social work, credentialing, privileging, and performance evaluation. The OIG also reviewed suicide prevention program clinical staff's scopes of practice, functional statements, and licensure. The OIG reviewed select suicide prevention program data from October 1, 2024, (one year prior to mental health leaders initiating assignment of therapy duties), through December 31, 2025. Specifically, the OIG reviewed two metrics—Veterans Crisis Line consult closure response time and suicide prevention program high risk for suicide patient record

[9] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide,* December 2022. The OIG acknowledges that suicide prevention coordinators and suicide prevention case managers share required program responsibilities.

[10] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide.*

flag (an alert in a patient's electronic health record to communicate to VA staff that a patient is at "high risk for suicide") reviews.[11]

The OIG interviewed leaders from VHA's Office of Care Management and Social Work Services and Office of Credentialing and Privileging; a VISN suicide prevention program manager; and the system's Chief of Staff, chief of credentialing and privileging, chief of social work, social work and mental health leaders, and suicide prevention program leaders and staff.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of the Inspectors General on Integrity and Efficiency's standards. During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts and documents. After using this artificial intelligence (AI) tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. Office of Healthcare Inspections teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, "*Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*"[12]

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 issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

[11] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide*.

[12] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

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

Inspection Results

1. Assignment of Psychotherapy Patients to Suicide Prevention Program Clinical Staff

The OIG did not substantiate that suicide prevention program clinical staff's ability to meet suicide prevention program requirements was limited by the assignment of additional psychotherapy duties.

The OIG reviewed the VA *Suicide Prevention Program Guide* and found suicide prevention coordinators are not precluded from providing additional clinical services. Further, system leaders may determine their unique staffing compositions to ensure all required suicide prevention program responsibilities are addressed.[13]

In an effort to be compliant with VHA clinical consult requirements, mental health leaders reported having implemented strategies to decrease the number of general mental health patients awaiting services and maximize system resources.[14] These strategies included ensuring the patients waiting were still interested in psychotherapy, offering community care, attempting to hire additional therapists, and assigning patients to mental health providers in other programs (such as inpatient mental health, suicide prevention, post-traumatic stress disorder, and substance abuse treatment teams).

The OIG learned that in September 2025, mental health leaders assigned each of the 18 suicide prevention program clinical staff, including suicide prevention coordinators, suicide prevention case managers, and care coordinators, one general mental health patient and expected them to begin weekly, time-limited psychotherapy. This assignment was in addition to their regular suicide prevention program duties. The OIG learned mental health leaders held informational sessions to alleviate staff's concerns about providing quality psychotherapy. The deputy chief of mental health also reported offering ongoing clinical consultation as needed.

When asked by the OIG, the VISN suicide prevention program manager, mental health leaders, and suicide prevention program leaders did not report concerns that the psychotherapy assignment affected clinical staff's ability to complete suicide prevention program duties.

To determine whether assigning psychotherapy duties influenced performance, the OIG reviewed two key metrics related to suicide prevention program clinical staff's completion of

[13] VA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program Guide.*

[14] Office of Mental Health and Suicide Prevention and Office of Integrated Veteran Care, "VHA Consult Use for Established Patients in Mental Health Standard Operating Procedure," September 3, 2025.

program responsibilities. Specifically, the OIG reviewed (1) Veterans Crisis Line consult closure response time and (2) suicide prevention program high risk for suicide patient record flag review data for the three months preceding and the three months following the psychotherapy assignment. According to VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center,* suicide prevention program clinical staff are responsible for ensuring Veterans Crisis Line requests are closed within three days.[15] Further, VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Guide*, defines the high-risk flag review metric as the percentage of high risk for suicide flags reviewed by suicide prevention program clinical staff within required VHA time frames.[16] The OIG found that suicide prevention program clinical staff remained at 99–100 percent compliant with Veterans Crisis Line consult closures and continued to review 97 percent of high-risk flags within required time frames. Given the high level of consult compliance and timely high-risk flag reviews, the OIG found no indication either metric was negatively affected by the introduction of psychotherapy.

2. Suicide Prevention Program Clinical Staff's Licensure, Position, and Scope of Practice

The OIG determined that although suicide prevention program clinical staff possessed the state licensure necessary to provide psychotherapy services to patients, 5 of the 18 staff members did not have a scope of practice that authorized them to do so. Additionally, the scopes of practice did not align with the 5 staff's licensure, position, or clinical assignment. The OIG found this misalignment likely applied to a larger number of the system's social workers.

Licensure

VA Handbook 5005/120, *Staffing*, specifies "persons hired or reassigned to social worker positions … in VHA must be licensed or certified by a state to independently practice social work …." Within VA, an advanced practice level social work license allows the individual to independently establish clinical diagnoses and provide psychotherapy and other mental health services (advanced practice procedures).[17]

The OIG confirmed that all 18 suicide prevention program clinical staff held active Licensed Clinical Social Worker licenses, verified as an advanced practice level license through the VHA National Social Work Program office's state licensure dashboard.

[15] VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center,* May 26, 2020, amended December 8, 2022.

[16] VHA Directive 1166, *Patient Record Flags,* November 6, 2023; VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Guide*.

[17] VA Handbook 5005/120, *Staffing*, September 10, 2019.

Position Classification and Clinical Assignment

According to VA Handbook 5005/120, individuals serving in a "senior social worker" position, must hold an advanced practice level license and be "assigned to a position that requires use of the advanced practice skills."[18] A document review revealed all suicide prevention program clinical staff held the position of "senior social worker." During interviews, the OIG learned that as part of their regular suicide prevention program duties, staff routinely provided advanced practice procedures, such as psychotherapy and mental health assessments, to patients.

Scope of Practice

VHA Directive 1110.02, *Social Work Professional Practice*, states "a scope of practice allows VA employees to function autonomously within a defined set of clinical duties."[19] VHA memorandum, August 21, 2025, emphasizes, "All VHA social workers must practice within their scope of practice, privileges, and professional licensure in all care settings."[20]

The OIG reviewed suicide prevention program clinical staff's scopes of practice to determine whether they were authorized to provide psychotherapy at the system and found two different social work scopes of practice. The OIG learned that traditionally, system social workers were under a scope of practice approved through the social work service line. However, in April 2025, the system's Medical Executive Committee approved a new social work scope of practice, which included the option for individual social workers to request or decline the inclusion of advanced practice procedures (providing psychotherapy, formulating mental health diagnoses, and conducting mental health assessments).

The OIG found 13 of 18 suicide prevention program clinical staff members were operating under the traditional social work scope of practice. Twelve of the 13 scopes of practice authorized staff to perform advanced practice procedures and were in alignment with staff's advanced practice licensure, position (senior social worker), and clinical assignment (suicide prevention program); however, one suicide prevention program staff's traditional scope of practice did not include all advanced practice procedures and did not accurately reflect the position or clinical assignment.

At the time of this inspection, the chief of social work reported being in the process of transitioning 321 system social workers from the traditional scope of practice to the 2025 scope of practice. Five suicide prevention program clinical staff members had transitioned to the 2025

[18] VA Handbook 5005/120.

[19] VHA Directive 1110.02, *Social Work Professional Practice,* August 16, 2024.

[20] Acting Assistant Under Secretary for Health for Patient Care Services, Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, Acting Assistant Under Secretary for Health for Integrated Veteran Care, "For Action: Social Work Professional Practice Standards in All Clinical Care Settings Including Dialysis and Kidney Medicine," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), August 21, 2025.

scope of practice. The OIG found four of the five staff members' approved scopes of practice did not authorize them to provide psychotherapy or other advance practice procedures that are inherent to their position and clinical assignment.[21] Further, the 2025 scope of practice states that the provision of services outside of the approved scope of practice can only be done in a life-threatening patient emergency.

The OIG found these four suicide prevention program clinical staff did not request advanced practice procedures on their scope of practice. Through an interview with the social work professional practice specialist, the OIG learned the professional practice specialist instructed suicide prevention program clinical staff not to request advanced practice procedures on the 2025 scope of practice. This decision, made primarily by the professional practice specialist and the chiefs of social work and credentialing and privileging, was partially based on an understanding that staff did not routinely provide psychotherapy. During an interview, VHA's National Director of Social Work reviewed the system's 2025 social work scope of practice with the OIG inspection team and voiced concerns that suicide prevention program clinical staff's scope of practice did not include advanced practice procedures, noting these interventions are "relevant to their daily work." The National Director of Social Work added that if the scope of practice did not include these procedures, performing those services would be practicing outside of what the system authorized them to do, which is a patient safety concern.

Due to the seriousness of this concern, the OIG team met with the System Director and senior leaders on January 8 and sent a memorandum on January 22, 2026. The OIG advised leaders that suicide prevention program clinical staff may be providing services outside of their approved scope of practice and requested leaders take action to ensure

- scopes of practice align with position responsibilities and assigned duties, and
- staff adhere to the terms of their approved scope of practice.

The OIG also advised system leaders that this finding likely applies to a larger number of social workers who transitioned to the 2025 scope of practice and were given the option to request or decline the inclusion of advanced practice procedures.[22]

Following an April 2026 OIG inquiry, the chief of social work provided documentation that three of the social workers who were transitioned to the 2025 scope of practice had modified scopes to include the provision of "psychotherapy and counseling." However, the OIG found that no additional advanced practice procedures, such as conducting mental health assessments or

[21] VA Handbook 5005/120.

[22] As of May 1, 2026, the system's chief of social work reported that 60 of the 321 social workers had transitioned to the 2025 social work scope of practice.

formulating diagnoses, were added to the modified scopes of practice. The OIG remains concerned that social workers may still be practicing outside of their approved scope of practice.

3. Social Workers: Licensed Independent Practitioners

The OIG learned that changes to the social work scope of practice were one component of a larger system initiative to recredential social workers as licensed independent practitioners through the medical staff structure; however, the OIG determined that during these efforts, system leaders inadvertently limited licensed clinical social workers' abilities to independently practice and perform their job responsibilities.

VHA Directive 1110.02, *Social Work Professional Practice*, states the chief of social work, or equivalent, is responsible for ensuring social workers practice "at the top of their education, skill, and licensure level and in accordance with their scope of practice, credentialing, privileging, and clinical assignment." Per the directive, "A social worker licensed at the independent practice level is considered a LIP [licensed independent practitioner] in VHA."[23]

Through policy review and an interview with VHA's National Director of Social Work, the OIG learned that licensed clinical social workers independently provide patient care either through a defined scope of practice approved by the chief of social work or through clinical privileges approved through the medical staff structure.[24] VHA's National Director of Social Work explained that social workers under a scope of practice are not part of the medical staff and are not included in the medical staff bylaws. Social workers who are granted privileges receive oversight through a standardized medical staff review process and are identified as licensed independent practitioners in the medical staff bylaws.

The OIG found the system's medical staff voted to recredential social work service line staff as licensed independent practitioners under a scope of practice through the medical staff structure. Toward this effort, leaders revised the medical staff bylaws to include social workers but did not identify them as licensed independent practitioners. Instead, social workers were listed in a category of providers who "practice under a Scope of Practice with appropriate supervision and/or collaboration."[25]

During an interview, the OIG reviewed the system's medical staff bylaws and the 2025 social work scope of practice with VHA's National Director of Social Work, who surmised that system leaders were "blending" two separate processes—scope of practice and privileging. The National Director of Social Work stated "… one of my biggest concerns is that they're … [system medical staff] looking at social workers, who are independently licensed, as dependent, the way their

[23] VHA Directive 1110.02.

[24] VHA Directive 1110.02.

[25] System, *Bylaws and Rules of the Medical Staff*, revised date, December 13, 2024, reviewed date January 15, 2025.

bylaws read, and that is not accurate." Similarly, National Credentialing and Privileging leaders expressed concerns and stated the changes to the medical staff bylaws limit the licensed clinical social workers' abilities to practice independently and carry out the duties of their positions.

The OIG found system leader's alignment of social workers through the medical staff structure under a scope of practice with supervision and/or collaboration does not allow social workers to function at the top of their education, skill, and licensure level or practice independently, which is inconsistent with VA and VHA policy. When a system has fewer independent practitioners available to provide care, patients' access to timely mental health services could be negatively affected.

Conclusion

The OIG did not substantiate that suicide prevention program clinical staff's ability to meet suicide prevention program requirements was limited by the assignment of additional psychotherapy duties. Mental health leaders took steps to decrease the number of patients waiting for psychotherapy in general mental health including offering community care, using existing system resources, and attempting to hire additional staff. The assignment of one patient per suicide prevention program clinical staff member did not affect staff's ability to complete required suicide prevention duties related to Veterans Crisis Line consults or high risk for suicide patient record flag reviews.

Suicide prevention program clinical staff had the appropriate licensure, position classification, and clinical assignment to provide psychotherapy; however, the approved scope of practice for five staff members did not allow them to conduct psychotherapy or other advanced practice procedures. As these procedures are inherent to their position, these staff were practicing outside of the approved scope of practice. Practicing outside of an approved scope of practice could pose patient safety concerns.

While recredentialing social workers as licensed independent practitioners through the medical staff structure, system leaders blended the scope of practice and privileging processes. By blending these processes, system leaders limited social workers' ability to practice independently and to function at the top of their education, skill, and licensure level as intended by VA and VHA policy.

The OIG made three recommendations to the System Director. The System Director concurred with the recommendations and will consult with VHA national program offices in modifying scopes of practice, amending medical staff bylaws, and ensuring social workers are identified as licensed independent practitioners.

The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–3

1. The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Office of Care Management and Social Work Services, takes appropriate steps so that licensed clinical social workers' scopes of practice are in alignment with their professional licensure, position classification, and clinical assignment in accordance with VA Handbook 5005/120, *Staffing,* and Veterans Health Administration Directive 1110.02*, Social Work Professional Practice*.

2. The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Office of Care Management and Social Work Services and Office of Credentialing and Privileging, reviews the system's actions to integrate social workers into the medical staff (including the revised medical staff bylaws and scopes of practice) in accordance with Veterans Health Administration Directive 1110.02, *Social Work Professional Practice*, and Veterans Health Administration Directive 1100.21(1), *Privileging.*

3. The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Office of Care Management and Social Work Services, takes appropriate steps so that social workers are identified as licensed independent practitioners, either through a scope of practice or privileges, in accordance with Veterans Health Administration Directive 1110.02, *Social Work Professional Practice*, and Veterans Health Administration Directive 1100.21(1), *Privileging*.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 2, 2026

From: Director, Department of Veterans Affairs (VA) Veterans Integrated Service Network (VISN) 2

Subj: VA Office of Inspector General (OIG) Report, Review of Suicide Prevention Program Staff Duties at the Atlanta VA Health Care System in Decatur, Georgia (VIEWS 15252808)

To: Director, Office of Healthcare Inspections (54HL03)
Executive Director – VHA Office of Integrity and Compliance (10OIC)

1. We appreciate the opportunity to review and comment on the OIG draft report, Review of Suicide Prevention Program Staff Duties at the Atlanta VA Health Care System in Decatur, Georgia. We are committed to ensuring Veterans receive quality care that utilizes the high reliability pillars, principles, and values. I reviewed the action plan provided by the facility and concur with the response.
2. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
3. Should you have any questions or require further information, please contact the VISN Quality Management Officer.

(*Original signed by:*)

Wendell Jones, MD, MBA

[OIG comment: The OIG received the above memorandum from VHA on October 2, 2026.]

Appendix B: System Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 2, 2026

From: Interim Executive Director, Atlanta VA Health Care System (508/00)

Subj: VA Office of Inspector General (OIG) Report, Review of Suicide Prevention Program Staff Duties at the Atlanta VA Health Care System in Decatur, Georgia (VIEWS 15252808)

To: Director, Veterans Integrated Service Network (VISN 2)

1. The Atlanta VA Health Care System appreciates the opportunity to review and comment on the OIG draft report. The facility concurs with the OIG recommendations and will implement the corrective actions as outlined in the accompanying response.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should additional information be required, please contact the Deputy Chief of Quality and Risk Management.

(*Original signed by*:)

J. Ronald Johnson, FACHE

[OIG comment: The OIG received the above memorandum from VHA on October 2, 2026.]

System Director Response

Recommendation 1

The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Office of Care Management and Social Work Services, takes appropriate steps so that licensed clinical social workers' scopes of practice are in alignment with their professional licensure, position classification, and clinical assignment in accordance with VA Handbook 5005/120, *Staffing,* and Veterans Health Administration Directive 1110.02*, Social Work Professional Practice.*

__X_Concur

____Nonconcur

Target date for completion: June 2026

Director Comments

The Atlanta VA Health Care System has modified the scope of practice as provided to OIG in our May 2026 response. This modification ensures that they are aligned with the professional licensure, position classification, and clinical assignment, in accordance with VA Handbook 5005/120 and Veterans Health Administration Directive 1110.02. All scopes of practice of the suicide prevention staff have been modified to align with licensure, position classification and clinical assignment, including providing psychotherapy.

OIG Comments

The OIG considers this recommendation open to allow time for leaders to submit documents to support closure.

Recommendation 2

The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Offices of Care Management and Social Work Services and Office of Credentialing and Privileging, reviews the system's actions to integrate social workers into the medical staff (to include the revised medical staff bylaws and scopes of practice) in accordance with Veterans Health Administration Directive 1110.02, *Social Work Professional Practice* and Veterans Health Administration Directive 1100.21(1), *Privileging.*

__X_Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

All scopes of practice of the suicide prevention staff have been modified to align with licensure, position classification and clinical assignment. Using the current template, the Medical Staff Bylaws will be revised to reflect that social workers are licensed independent practitioners who do not require supervision and/or collaboration.

Recommendation 3

The Atlanta VA Health Care System Director, in consultation with Veterans Health Administration's Office of Care Management and Social Work Services, takes appropriate steps so that social workers are identified as licensed independent practitioners, either through a scope of practice or privileges, in accordance with Veterans Health Administration Directive 1110.02, *Social Work Professional Practice,* and Veterans Health Administration Directive 1100.21(1), *Privileging*.

_X__Concur

____Nonconcur

Target date for completion: March 2027

Director Comments

Currently, most social workers are credentialed as Non-LIPs (Licensed Independent Practitioner). In 2021, the Medical Staff voted that social workers would be credentialed as LIPs on a scope of practice. Social workers are already considered LIPs by their licensure. In accordance with the Medical Staff Bylaws, to be credentialed as an LIP requires both the licensure of the occupation and facility approval by the Medical Staff. The credentialing process required approximately 400 social workers to be credentialed as LIPs on a scope of practice through the medical staff process has been underway since 2025. To support progress, the Credentialing and Privileging department is currently undergoing a structural reorganization to assist the LIP Team. Thus far, the credentialing of 94 social workers has been initiated, and of those, 72 have been completed. Approximately 300 social workers remain to be recredentialed as LIPs and credentialed through the medical staff process. As we continue the process of credentialing the approximate 300 remaining social workers as LIPs on a scope of practice (via the Medical Staff process), we are still following the credentialing requirements for all social workers.

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