US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Mountain Home Healthcare System in Tennessee

Healthcare Facility Inspection	25-04252-256	August 28, 2026

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Executive Summary

The VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the VA Mountain Home Healthcare System (the facility) from December 9 through 11, 2025. The facility is rated as *high complexity* and in fiscal year 2025, provided direct care to about 67,000 patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences. The OIG made no recommendations.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy. The OIG made no recommendations.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement. The facility did not comply with VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, because it lacked service-level workflows that outline staff roles in the test result communication process. The OIG made one recommendation.[3]
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[4] The OIG made no recommendations.
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of

[1] VHA classifies facilities based on their complexity level. High-complexity facilities have "medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY 2025 Through September," VHA Support Service Center, accessed March 5, 2026, https://reports.vssc.med.va.gov.(This website is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

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

[4] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

homelessness or have been recently incarcerated. The OIG made no recommendations.

What the OIG Recommended

1. Facility leaders take appropriate actions so staff develop a written workflow for each service that is consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see the response in the report body and appendixes B and C).[5] Based on information provided, the OIG considers the recommendation closed.

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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 inspection. 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.

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General (OIG), Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[6] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[7]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[8]

Patient Safety: VHA has programs to identify and reduce system vulnerabilities and risks of harm to veterans.[9]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[10]

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[6] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[7] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[8] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[9] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

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

The VA Mountain Home Healthcare System (the facility) serves a 41-county area in northeastern Tennessee, western Virginia, and southern Kentucky. The medical center in Mountain Home is named after a local veteran, James H. Quillen, a World War II Navy lieutenant with decades of service in Tennessee government. The site began as a home for disabled soldiers in 1903. In 1920, it became a sanatorium to treat returning World War I soldiers with tuberculosis and influenza. The facility includes community-based outpatient clinics in Tennessee and Virginia and maintains affiliations with a medical school and a college of pharmacy.[11]

Figure 1. *Facility photo.*
Source: "VA Mountain Home Health Care," VA, accessed September 19, 2025, https://www.va.gov/mountain-home-health-care.

The OIG inspected the facility from December 9 through 11, 2025. Its budget for fiscal year (FY) 2025 was approximately $1.1 billion, which included approximately $4 million allocated for care provided in the community.[12] It has 70 community living center, 88 domiciliary, 85 inpatient, and 24 inpatient mental health beds.[13]

The executive leaders referred to throughout this report include the Director; Chief of Staff; Deputy Chief of Staff; Associate Director for Patient Care Services; Acting Associate Director; Assistant Director; and Chief of Quality Management. The Deputy Chief of Staff, who started in December 2018, had the longest tenure, and the Director, who was assigned to an interim role in September 2024, was appointed as the permanent Director in November 2025.

[11] "History," VA, last updated October 17, 2023, https://www.va.gov/mountain-home/history; "About Us," VA, last updated April 2, 2024, https://www.va.gov/mountain-home/about-us; The clinics are in Johnson City, Knoxville, LaFollette, Morristown, Mountain City, Rogersville, and Sevierville, Tennessee, and Bristol, Jonesville, Norton, and Vansant, Virginia. "Locations," VA, last updated April 2, 2024, https://www.va.gov/mountain-home/locations.

[12] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[13] A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/VA_CLC. A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/dchv.

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[14] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and assess their level of trust in VA).[15] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[16]

System Shocks

During a December 2025 interview, the Director reported two system shocks experienced over the past year. First, Hurricane Helene caused flooding and significant damage to the community in September 2024 that prompted facility staff's emergency actions. As a result, the Director stated they have implemented an annual check of employee contact information due to challenges reaching employees.[17] Second, an investigation was conducted into serious allegations of employees' prohibited or improper conduct (inappropriate interpersonal relations, sexual harassment, and assault).[18]

The Director, who was serving in an interim capacity in September 2024 when Hurricane Helene struck, explained that executive leaders quickly activated their emergency response plan to manage the event. The Director highlighted employees' dedication despite personal losses. For example, one employee described feeling helpless about the condition of their own home, but they focused on what they could do to help veterans during this time. Nursing staff called veterans to inquire about their safety. During one call, a nurse warned a veteran about serious flooding in the area and instructed them to contact emergency services, who subsequently rescued the veteran and their spouse by helicopter.

[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] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[16] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[17] National Oceanic and Atmospheric Administration, National Weather Service, "*National Hurricane Center Tropical Cyclone Report*, *Hurricane Helene (AL092024)*, 24–27 September 2024," April 8, 2025.

[18] House Committee on Veterans' Affairs, "Committee Probes VA on Disturbing Mountain Home VA Sexual Harassment and Assault Allegations," press release, September 5, 2024, https://veterans.house.gov/news/6537.

The Director said another system shock was the abrupt removal of the former Director and Associate Director from their positions in July 2024 during an investigation into employees' alleged inappropriate relationships, sexual harassment, and assault. Executive leaders at the time of the inspection in December 2025 characterized the event as a major disruption to the facility that undermined veterans' confidence and employees' morale.

To address concerns about the employee misconduct and removal of leaders from positions, the Director, who started in September 2024 as the interim Director, took several actions, one of which was conducting a town hall to inform veterans about what executive leaders knew, actions they had taken, and the leaders' expectations moving forward. To rebuild trust, executive leaders encouraged employees to direct questions to them rather than rely on information from external sources, such as the media. They also visited work areas weekly to be accessible and approachable. Recognizing there was limited leader engagement in the community-based outpatient clinics, they also created employee focus groups within the clinics to discuss concerns. They described developing a formal process to ensure facility leaders address all allegations promptly and escalate them to executive leaders as needed to help avoid a recurrence of the incidents.[19]

The Associate Director for Patient Care Services described learning valuable lessons from the shocks: "[C]reate an environment where leaders demonstrate consistency, transparency, and accountability; ensure employees feel valued; and promote quality care." The leader also emphasized that executive leaders work diligently to strengthen trust with veterans and employees.

Employee Experiences

Executive leaders said they previously relied on the VA All Employee Survey as a method to evaluate employee satisfaction.[20] However, because VA did not administer the survey in FY 2025, the OIG asked how leaders assessed employee engagement and satisfaction in its absence. One leader said discontinuing the All Employee Survey negatively affected employee morale, and another leader hoped it would return next year. Executive leaders did not plan to

[19] The facility leaders referred to in this report may include managers, supervisors, and service chiefs who implement policies and maintain daily operations.

[20] The All Employee Survey is an annual, voluntary 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.

administer a facility employee survey at the time of the December 2025 inspection and stated they were unaware if the Veterans Integrated Service Network (VISN) will conduct one.[21]

Most OIG questionnaire respondents indicated the culture was improving and they felt comfortable suggesting actions to improve the work environment (see figure 2).[22]

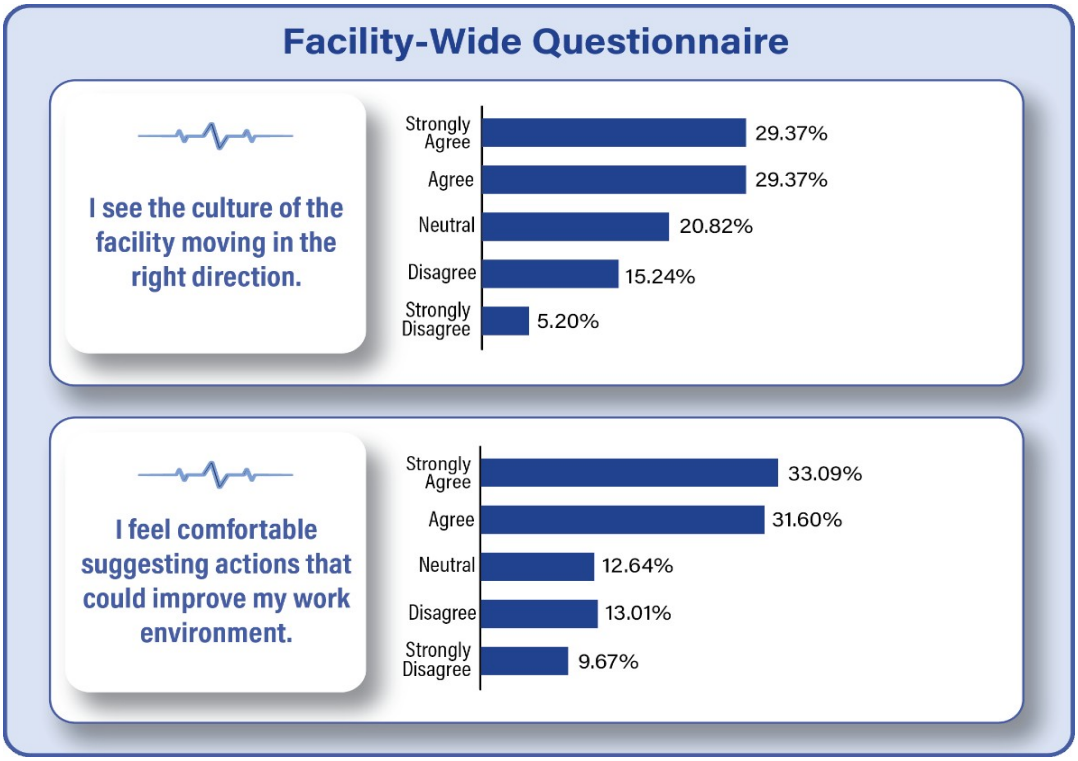

Figure 2. *Employee perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Executive leaders explained they partner with service chiefs, nurse managers, and nonclinical service leaders to visit employees in their work areas. During one of those weekly visits, an employee told executive leaders the physical therapy service needed more patient lifts. Leaders collaborated with the engineering service to add additional patient lifts in this location, which

[21] VA administers healthcare services through a nationwide network of regional systems referred to as Veterans Integrated Service Networks (VISNs). "Veterans Integrated Service Networks," VA, last updated August 14, 2026, https://department.va.gov/visns. 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 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 inspection. 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.

[22] About 2,800 employees worked at the facility when the OIG submitted the questionnaire, and roughly 10 percent responded.

enhanced patient safety and care. The Acting Associate Director said leaders document the concerns and ideas they receive during these visits, and update employees on any actions they take the following month. The Director reported believing this approach creates a more collaborative work environment across services and empowers employees to share their concerns.

Veteran Experiences

Patient advocates who responded to the OIG questionnaire indicated leaders were responsive to veterans' concerns and effectively addressed them. However, respondents highlighted some of the veterans' most common complaints, including disagreements with providers regarding their treatment plans and frustration with the inability to reach facility staff via telephone. The Director explained that when a veteran disagrees with their treatment plan, they sometimes request a new provider, and the patient advocate elevates this concern to executive leaders who honor the preference when possible.

To better understand the concerns with reaching staff by telephone, executive leaders said they toured the facility's call center, spoke to employees, and identified opportunities for improvement. In April 2025, they added a brief prerecorded introduction to the phone system to alert the caller of the service or location they had reached, redirected incoming clinic calls to the call center if they were not answered within three minutes, and verified phone numbers and extensions to ensure call center operators accurately transfer calls. Leaders determined the improvements were successful based on decreased complaints, faster answered calls, and fewer abandoned calls (terminated by the veteran prior to speaking to a person).

To further improve veterans' experiences, the Director said leaders plan to establish an advisory board in the coming year. With representation from veterans service organizations (groups that help veterans and their families understand and navigate VA benefits), the board will provide additional insight into veterans' concerns and opportunities to improve system processes.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[23] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[24]

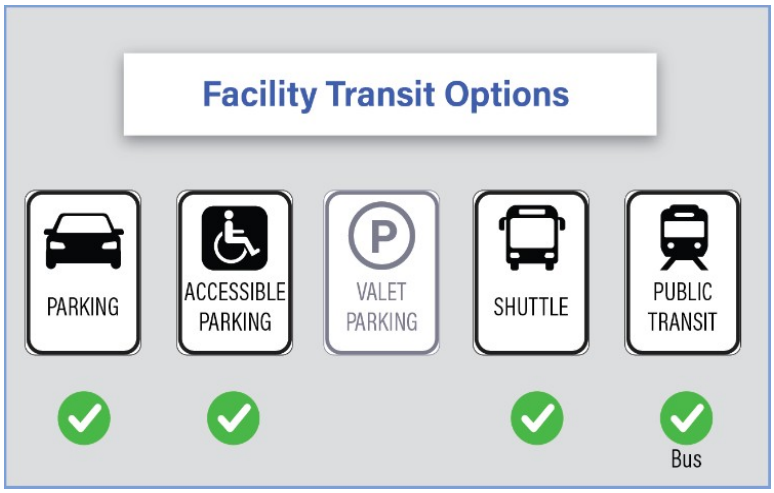

Figure 3. *Transit options for arriving at the facility.*
Source: OIG analysis of facility staff questionnaire responses, a parking lot map, leader's response to document request, and a shuttle schedule.

General Inspection

The facility's parking garage had accessible spaces for those with disabilities, and several facility buildings were connected by an enclosed walkway. The main entrance was generally clean and well-lit, with seating areas and an information desk with staff available to assist veterans.

The team noted maps and directional signs on the walls throughout the buildings, as well as multiple features to aid veterans with sensory impairments (see figure 4). Televisions had closed captioning capability, but OIG inspectors did not see it in use in common areas. Facility staff promptly resolved the issue.

Additionally, inspectors found that some crosswalks at the facility lacked detectable warning surfaces (a critical safety feature to alert individuals with visual impairments when walkways

[23] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[24] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* 2025; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

Figure 4. *Accessibility tools available to veterans with impairments.*
Source: OIG team observations, facility staff interview, and questionnaire responses.

transition onto roadways), as required by the *VA PG 18-10, Site Design Manual*.[25] However, the chief of engineering reported being aware of the issue and already had an approved project to correct it, so the OIG did not make a recommendation.

The OIG team found the inspected clinical and nonclinical areas generally clean and well maintained, with clear exit paths and secure supply and medication rooms. However, the team identified safety hazards related to supply and equipment management practices, including unlabeled cleaning products, as well as clean items stored in biohazard rooms in the community living center and medical and surgical unit. The Code of Federal Regulations (title 29, section 1910.1200(f)) requires warning labels for hazardous chemicals, and VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs* requires separation of soiled and clean supplies.[26] Additionally, in the dermatology clinic and the primary care team 5 room, the OIG team found that staff did not monitor temperature and humidity for supplies, as required by VHA Directive 1761, *Supply Chain Management Operations*.[27] Since leaders again corrected all these issues immediately, the OIG did not make recommendations for further action.

The inspection team did not find any repeat environment of care problems from prior oversight reports. The safety manager explained that the environment of care committee reviews issues identified by accreditation agencies and analyzes trends from internal inspections to decide where to focus improvement efforts.

[25] VA, *PG-18-10*, *Site Design Manual*, February 1, 2013, revised March 1, 2024.
[26] 29 C.F.R. § 1910.1200(f) (2025); VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 27, 2023.
[27] VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility did not have workflows (written documents that describe the roles of various team members in the process to communicate test results) for each applicable service, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*.[28] The OIG team reviewed several service-specific standard operating procedures and found they did not meet the service-level workflow criteria for staff communication of test results. For example, workflows must include which team members can communicate test results and how those results are conveyed. If providers do not communicate test results in a timely manner, the risk increases that diagnoses will be missed or delayed and can lead to patient harm.

Recommendation 1

Facility leaders take appropriate actions so staff develop a written workflow for each service that is consistent with Veterans Health Administration Directive 1088(1), *Communicating Test Results to Providers and Patients*.

_X_ Concur

____Nonconcur

Target date for completion: Completed

Director Comments

The Chief of Staff (COS) and Quality Management (QM) completed a comprehensive review of VHA Directive 1088(1), Communicating Test Results to Providers and Patients (dated July 11, 2023; amended September 20, 2024), to ensure full alignment with all required standards. Requirements outlined in the Directive were used to develop service-specific Communication of Test Results workflows. These workflows were formalized into flow charts for each clinical service and incorporated as appendices to MCP 11-025, Communication of Test Results, thereby ensuring the medical center's governing policy documents fully reflect current VHA expectations.

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

The Directive, the revised MCP, and all service-specific workflow charts were disseminated to each identified clinical service for implementation. To ensure operational compliance, the workflows were reviewed with clinical staff, and structured training was provided to all services responsible for communicating test results. This training occurred during the All-Medical Staff meeting, with additional reinforcement delivered during monthly service-level staff meetings. Completion of training was monitored by Quality Management to verify that all required staff received instruction.

This action ensures that all services follow standardized, Directive-compliant processes for timely and effective communication of test results and establishes a clear accountability structure consistent with OIG expectations for sustained compliance.

OIG Comments

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

Action Plans and Process Improvements

When the OIG team inspected the facility in December 2025, there were no unimplemented or recurring recommendations from the 2022 OIG Comprehensive Healthcare Inspection Program report or Joint Commission survey.[29] During an interview, the patient safety manager described how executive leaders support patient safety, including meeting together at morning safety huddles (meetings to identify and prioritize potential risks) to review patient safety reports for adverse events and close calls (incidents that could have led to adverse events). The manager said leaders provide input during huddles on safety event reports and root cause analyses (formal, team-based, systems-level investigations to review factors contributing to adverse events and close calls).[30]

The systems redesign coordinator described identifying performance improvement opportunities from several sources, including monthly meetings, facility performance data, patient safety incident reports, and staff suggestions. The coordinator also reported other staff engagement activities such as project recognition awards, an annual performance improvement fair, and a quarterly newsletter.

[29] VA OIG, *Comprehensive Healthcare Inspection of the Mountain Home VA Healthcare System in Tennessee*, Report No. 21-03311-15, November 21, 2022; The Joint Commission, *Final Accreditation Report*, *James H. Quillen VA Medical Center*, March 7, 2023.

[30] VA, *Leader's Guide to Foundational High Reliability Organization (HRO) Practices*, July 2024; VHA Directive 1050.01(1).

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[31] The OIG evaluated facilities' primary care and community care staff vacancies, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

The facility delivers primary care services through 65 teams across its locations. At the time of the OIG inspection in December 2025, only 33 of the teams were fully staffed. Primary care leaders identified vacancies for providers, registered nurses, licensed practical nurses, and medical support assistants.

The OIG team found the facility's primary care teams averaged 92 percent of their expected capacity as to the size of their panels (patients assigned to a primary care team), as defined in VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*. However, 21 of the 65 teams exceeded 100 percent panel capacity.[32] The team also found that average new patient appointment wait times rose from approximately 19 days in the third quarter of FY 2024 to approximately 43 days in the third quarter of FY 2025. Wait times for established patients remained just under 4 days during the same period. The group practice manager stated the biggest reason for the increase in wait times was the population growth in the Knoxville area, adding that location has the largest number of new patients waiting over 20 days for an appointment. The Code of Federal Regulations (title 38, section 17.4040) states that patients may be referred to community providers if the wait time is greater than 20 days.[33]

To increase timely access to care, facility leaders added two new patient appointments to the daily schedule for providers who were under 105 percent panel capacity. The OIG found that for May 2026, new patient appointment wait times had decreased to approximately 23 days and established patients were just over 3 days. The OIG did not make a recommendation given leaders' ongoing actions.

[31] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

[32] The directive states the capacity of primary care panels is based on variables such as staffing, number of rooms, and provider type. VHA Directive 1406(3), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 16, 2026.

[33] 38 C.F.R. § 17.4040 (2025).

Community Care Staffing and Access to Care

At the time of the inspection in December 2025, the chief of community care told the OIG team the program was allocated 92 staff, including two vacant medical support assistant positions. The chief stated this was 10 positions fewer than in 2024, despite a 26 percent increase in workload over the previous two years. To support the increased work in the year leading up to the site visit, the chief reported using enough overtime to equate to 10 full-time employees. Community care staff said additional positions would help them meet patients' needs more quickly and enhance care coordination for those with complex needs. The Chief of Staff told the team that executive leaders evaluated staffing and anticipated hiring additional nursing and administrative staff.

The inspection team found that from January through July 2025, the average time it took for staff to successfully schedule a community care appointment was 11 days, while the requirement in VHA's *Consult Timeliness Standard Operating Procedure* is 7 days.[34] Community care leaders attributed delays to staffing vacancies and the lack of specialty providers in rural areas where patients reside. The community care chief stated that appointment wait times were approximately 50 percent below the VHA national average. In an effort to mitigate delays, staff also described a process improvement project that added a checklist to the facility provider's referral order, which helped decrease delays in ordering tests needed for the referral, and shortened patient wait times. The OIG found that in May 2026, the average time it took for staff to schedule a community care appointment had risen to approximately 14 days, but the facility remains well below the national average of over 25 days. The OIG did not make a recommendation because of leaders' ongoing actions.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader

[34] VHA, Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[35]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[36] HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[37] The facility's acting homeless program supervisor reported the measures did not apply because the program did not have contracted emergency residential services or low-demand safe haven beds.

Performance and Improvement Highlights

- The facility's acting homeless program supervisor said staff engage veterans experiencing homelessness through street outreach (facility program staff going into the community to talk with veterans) and visits to shelters and encampments. Hospital providers, veteran service organizations, and social service agencies also send veterans to the program.
- The supervisor said they refer veterans to a large Knoxville shelter; however, rural areas have limited resources and there are service barriers such as poor internet and cell phone coverage. As a result, staff partner with rural community organizations to connect veterans to services. The acting section chief for mental health community integrated services noted that staff use other options when no shelter is available, such as emergency hotel funds from community agencies.
- The acting section chief described an FY 2025 event in Knoxville to reduce the number of veterans without shelter. Staff engaged 39 veterans, provided same-day

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

[36] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[37] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

short-term housing, and connected them to permanent housing. A public housing agency issued six same-day vouchers.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[38] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[39]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[40]

Performance and Improvement Highlights

- The facility fell short of the voucher use (HMLS3) target in FY 2025. The facility's program supervisor attributed this to barriers such as rising housing costs, limited affordable housing, and a shortage of landlords willing to accept housing vouchers.
- To increase voucher use, staff worked with the local public housing agency to develop Liberty Place, a 32-unit complex that offers affordable, permanent housing for veterans. After its success, the mayor's office began building 20 tiny homes next to the site to provide more housing for veterans. Staff also worked with community partners, including the Knoxville Police Department, to identify veterans experiencing homelessness.
- The program also did not appear to reach the employment (VASH3) target in FY 2025 due to data entry issues. Staff said inaccurate employment status documentation was the basis for the reported shortfall, so they now review the homeless program database monthly to ensure the numbers are accurate.

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

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

[40] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[41] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Programs each fiscal year (performance measure VJP1).[42]

Performance and Improvement Highlights

- The facility met the enrollment (VJP1) target for FY 2025. An outreach specialist said they identify veterans by working with local jails, prisons, treatment courts (which supervise veterans through a program that provides treatment and other services), attorneys, probation offices, and community agencies.[43]
- The outreach specialist shares program information and attends monthly reentry meetings (for veterans nearing release into the community) with probation and court staff and builds relationships with public defenders.

Conclusion

To assist leaders in evaluating the quality of care at the VA Mountain Home Healthcare System, the OIG conducted an inspection across five domains. The OIG made one recommendation related to service-level workflows for test result communications to patients and providers. Facility leaders have started to implement corrective actions, which resulted in the OIG closing recommendation 1. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

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

[42] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

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

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[44] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility from December 9 through 11, 2025. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel for further review.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[45] 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, documents, questionnaire responses, and physical observations. After using this 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. The inspection 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*.[46]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[47] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[44] Accreditation reports covered the time frame of October 1, 2021, through September 30, 2024—the most recent available at the time of the inspection.

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

[46] 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.

[47] 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[48] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 14, 2026

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

Subj: Healthcare Facility Inspection of the VA Mountain Home Healthcare System in Tennessee

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

Chief Integrity and Compliance Officer (10OIC)

1. I have reviewed the findings and recommendations in the OIG report entitled, Draft Report: Healthcare Facility Inspection of the VA Mountain Home Healthcare System in Tennessee. 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 Mountain Home Healthcare System in Tennessee.

(Original signed by:)

Anthony M. Stazzone, MD, MBA, FACP
V3: Health Service Area 3.1-Executive Director
VA MidSouth Healthcare Network

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 12, 2026

From: Medical Center Director, James H. Quillen VA Medical Center (621/00)

Subj: Healthcare Facility Inspection of the VA Mountain Home Healthcare System in Tennessee

To: Director, MidSouth Healthcare Network (10N9)

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the James H. Quillen VA Medical Center (JHQVAMC), in Mountain Home, Tennessee. I appreciate the collaboration and professionalism demonstrated by the OIG and the Healthcare Facility Inspection team throughout the inspection process.
2. I concur with the draft report and OIG's recommendation.
3. I respectfully request closure of Recommendation 1 at publication, as all required corrective actions have been successfully implemented and verified.
4. The JHQVAMC is committed to providing the highest quality of care to our Nation's Veterans. Incorporating this recommendation further strengthens our efforts to improve system reliability, enhance patient safety, and advance our progress toward high reliability.
5. Questions or comments related to this Memorandum may be directed to the Interim Chief of Quality, JHQVAMC.

(Original signed by:)

Martina Malek, FACHE
Medical Center Director
James H. Quillen VA Medical Center

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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.