US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA North Florida/South Georgia Veterans Health System in Gainesville

Healthcare Facility Inspection	**24-00604-121**	**May 20, 2025**

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Executive Summary

The Office of Inspector General's (OIG's) mission is to serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs (VA). Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA North Florida/South Georgia Veterans Health System (facility) from June 4 through 6, 2024.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Leaders identified unique aspects of the organization's culture as the facility's size and complexity, and the annual occurrence of hurricanes. The facility includes two inpatient sites that are about 50 miles apart, and a large outpatient clinic in Jacksonville, Florida, which is about 75 miles from the main medical facility in Gainesville. To ensure executive leaders supported employees equally across a large area, the Director created new deputy director positions at each site.

The OIG administered a staff questionnaire prior to the site visit. Responses to the questionnaire indicated that staff had concerns about the culture of the facility moving in the right direction; however, they generally felt empowered to suggest ways to improve their work environment. Staff also indicated stress and burnout as reasons they were considering leaving the facility. Leaders felt employees were generally happy to work there but acknowledged stress being a concern. Leaders stated they instituted an open door policy to discuss staff's concerns.

[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.

Leaders discussed meeting with veterans service organization representatives on a quarterly basis to discuss veterans' concerns.[2] Additionally, they met with representatives informally when needed to address specific issues. Leaders shared that patient advocates address veterans' concerns and coordinate responses with staff, as well as identify trends in veterans' complaints.[3]

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 found unlabeled broken equipment, dirty and damaged items in clean storage areas, unclean patient care locations, walls with chipped or peeling paint, and exposed piping. The OIG also identified deficiencies The Joint Commission previously noted during a 2022 survey: biomedical equipment overdue for inspection, unsecured medications, inappropriate oxygen storage, dirty food storage area, and expired supplies. The OIG recommended leaders fix these environment of care deficiencies.

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 findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found facility staff managed communication of urgent test results to providers. Although the facility had no open recommendations from previous inspections, the OIG discovered staff did not sustain compliance with Joint Commission standards, as noted above. Quality staff developed a survey readiness sustainment plan and presented it to the Executive Leadership Board but had not implemented it at the time of inspection. The OIG recommended leaders sustain compliance with accreditation standards.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation

[2] VSOs 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.

[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/.

affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[4]

The OIG found that primary care teams were not fully staffed at the time of the visit and had a number of provider, registered nurse, clinical associate, and administrative associate position vacancies. Despite the vacancies, leaders prioritized filling positions, used recruitment and retention incentives, and shifted workload where appropriate to maintain access and minimize disruptions to patient care. Primary care staff expressed concerns related to the administrative workload, and primary care leaders addressed these concerns by reducing nonmandatory clinical reminders and view alerts (notifications in the electronic health record system) and leveraging technology to streamline clinical documentation. Primary care team members said they were aware of these efforts and felt facility leaders were addressing workload concerns and improve efficiency.

The OIG found veteran enrollment increased from fiscal year 2022 to fiscal year 2023 and primary care leaders attributed the increase to population growth in the service area. Primary care providers said toxic exposure screenings led to longer appointments because staff addressed veterans' concerns about exposures, clinical symptoms, and potential future health conditions. Primary care leaders anticipated this workload would decrease as staff focused on veterans who previously reported toxic exposures.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identified and enrolled veterans and assess how well the programs met veterans' needs. The OIG found the facility had active programs that met veterans' needs. Staff worked closely with community partners to identify and enroll eligible veterans, although program staff described barriers to enrollment, such as limited contact during the COVID-19 pandemic and veterans turning down engagement efforts, while housing program staff reported a lack of affordable housing and staff vacancies as barriers.

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

What the OIG Recommended

The OIG made seven recommendations for improvement.

1. The Associate Director of Operations ensures staff maintain, inspect, and test medical equipment.
2. The Deputy Chief of Staff ensures staff secure all medications from unauthorized access.
3. The Associate Director of Patient Care Services ensures staff appropriately store oxygen tanks.
4. The Associate Director ensures staff clean all food storage areas.
5. The Associate Director of Operations ensures staff remove expired supplies from storage areas.
6. The Associate Director of Operations ensures staff mark equipment that needs repair and separate it from equipment available for use and remove dirty items from clean storage areas.
7. Facility leaders ensure sustained compliance with Joint Commission accreditation standards.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and Facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D and the responses within the report body for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

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

Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans service organization

FACILITY IN CONTEXT

VA North Florida/South Georgia Veterans Health System
Gainesville, Florida
Level 1a-High Complexity
Alachua County
Hospital Referral Region: Gainesville

Description of Community

POPULATION

Female **1,049,436**	Male **1,016,131**
Veteran Female **20,177**	Veteran Male **158,132**

Homeless - State **25,959**
Homeless Veteran -State **2,279**

MEDIAN INCOME

$47,465

EDUCATION

84% Completed High School
40% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **441**

SUBSTANCE USE

30.7% Driving Deaths Involving Alcohol
20.4% Excessive Drinking
824 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION

Drive Alone	645,947
Carpool	74,774
Work at Home	66,409
Other Means	18,454
Walk to Work	11,097
Public Transportation	7,195

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**28.5 Minutes, 25.5 Miles**
Specialty Care	**44 Minutes, 36.5 Miles**
Tertiary Care	**61 Minutes, 47.5 Miles**

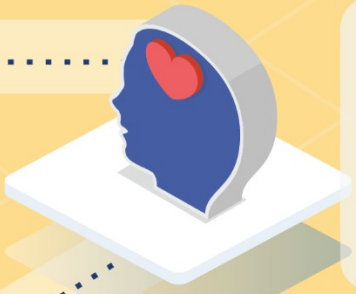
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **55,047**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	40%
<65 without Health Insurance	19%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

42,148

358 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.72 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
19	37

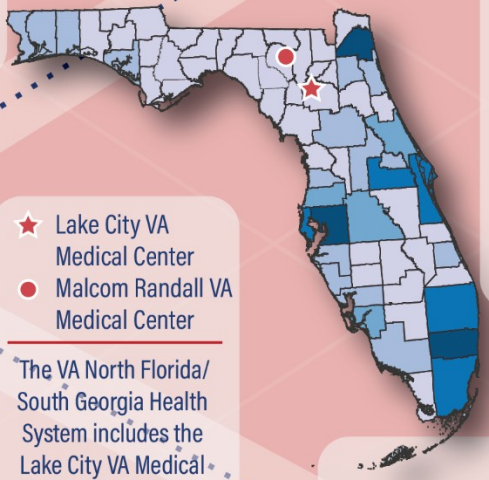
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	157K
Unique Patients VA Care	151K
Unique Patients Non-VA Care	68K

COMMUNITY CARE COSTS

Unique Patient	$16,458
Outpatient Visit	$271
Line Item	$366
Bed Day of Care	$279



- Lake City VA Medical Center
- Malcom Randall VA Medical Center

The VA North Florida/South Georgia Health System includes the Lake City VA Medical Center in Lake City, FL and Malcom Randall VA Medical Center in Gainesville, FL. The OIG visited the Malcom Randall VA Medical Center.

STAFF RETENTION

Onboard Employees Stay <1 Yr	10.02%
Facility Total Loss Rate	11.26%
Facility Retire Rate	2.72%
Facility Quit Rate	7.47%
Facility Termination Rate	0.89%

VETERAN POPULATION

0.03% 1.37% 2.71% 4.05% 5.39% 6.69%

See Appendix B: Facility in Context Data Definitions for a detailed description of data displayed.

Contents

Background and Vision

The Office of Inspector General's (OIG's) mission is to conduct meaningful independent oversight of the Department of Veterans Affairs (VA). The OIG's Office of Healthcare Inspections focuses on the Veterans Health Administration (VHA), which provides care to over nine million veterans through 1,321 healthcare facilities.[1] VHA's vast care delivery structure, with its inherent variations, necessitates sustained and thorough oversight to ensure the nation's veterans receive optimal care.

The OIG established the Healthcare Facility Inspection (HFI) cyclical review program to help accomplish its mission. HFI teams routinely evaluate VHA medical facilities on an approximately three-year cycle. Each cyclic review is organized around a set of content domains (culture, environment of care, patient safety, primary care, and veteran-centered safety net) that collectively measure the internal health of the organization and the resulting quality of care, set against the backdrop of the facility's distinct social and physical environment. Underlying these domains are VHA's high reliability organization (HRO) principles, which provide context for how facility leaders prioritize the well-being of staff and patients.

Figure 1. *VHA's high reliability organization framework. Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."*

HFI reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and

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

increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

High Reliability Organization Framework

HROs focus on minimizing errors "despite highly hazardous and unpredictable conditions," such as those found in healthcare delivery settings.[2] The aviation and nuclear science industries used these principles before the healthcare sector adopted them to reduce the pervasiveness of medical errors.[3] The concept of high reliability can be equated to "persistent mindfulness" that requires an organization to continuously prioritize patient safety.[4]

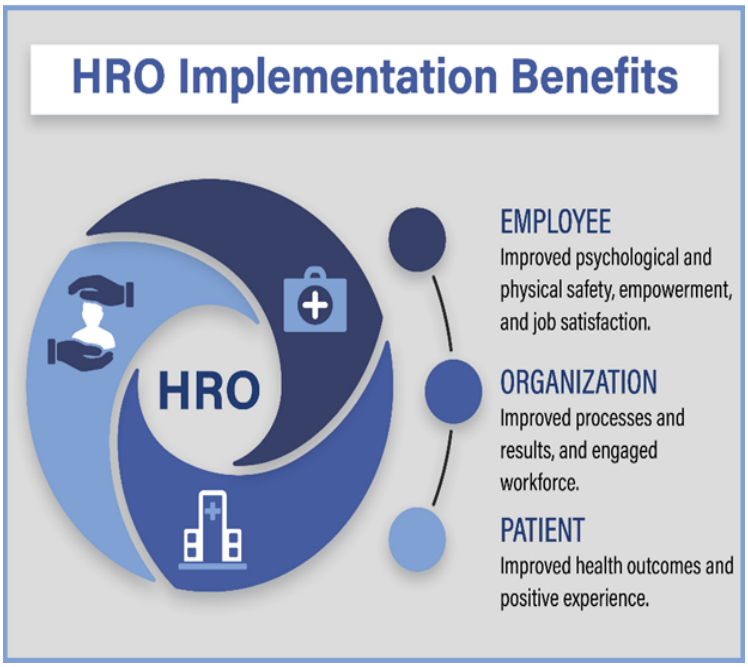


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

In 2018, VHA officially began the journey to become an HRO with the goals of improving accountability and reliability and reducing patient harm. The HRO framework provides the blueprint for VHA-wide practices to stimulate and sustain ongoing culture change.[5] As of 2020, VHA implemented HRO principles at 18 care sites and between 2020 and 2022, expanded to all VHA facilities.[6]

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient

[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.

outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety 18*, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

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

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The VA North Florida/South Georgia Veterans Health System (facility) is comprised of three major sites: inpatient medical centers in Gainesville and Lake City, Florida; and an outpatient clinic in Jacksonville, Florida. According to the Systems Redesign Coordinator, at the time of the inspection, the facility's senior leaders included an Executive Director (Director), Deputy Executive Director, Chief of Staff, Deputy Chief of Staff, Associate Director of Patient Care Services, acting Deputy Nurse Executive, Associate Director, acting Associate Director of Operations, and two Assistant Directors.

According to the Systems Redesign Coordinator, the Director had served in the role for a year and a half, and served in an acting capacity for six months prior to that. The Chief of Staff was the most tenured leader and had been the role for a little over four and a half years. The acting Associate Director of Operations had been in the role for three months, and the permanent position had been vacant for seven months. In fiscal year (FY) 2023, the facility's budget was approximately $2 billion. The facility had 611 operating beds (314 hospital, 221 community living center, and 76 domiciliary beds).[13]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed December 2, 2024, 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 December 2, 2024, 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.

leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[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] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18] The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks.

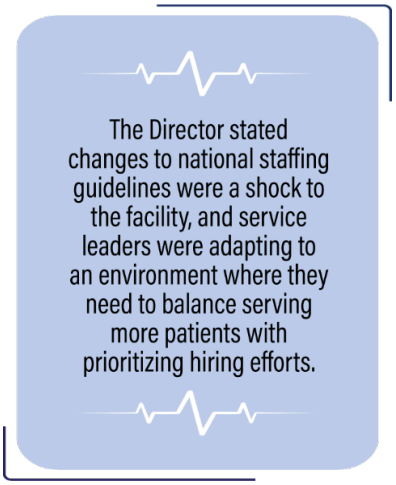


Figure 4. *Facility systems shocks.*
Source: OIG interview.

Leaders discussed two system shocks that affected the organization: turnover in senior leadership positions and changes to national staffing guidelines. In the OIG questionnaire, staff identified turnover in key leadership positions as the most significant system shock. Although leaders reported the facility had three directors over the last three years, the Director stated that many executive team members had served in their positions long enough that these transitions were not a crippling shock.

Regarding changes in the staffing guidelines, leaders stated that, in the past, service chiefs determined staffing priorities and could hire staff, as long as they stayed within the assigned budget allocation. However, VHA issued guidance in the previous six months for leaders to maintain staffing at the FY 2023 levels, which changed that practice. In response to the new guidelines, service leaders discussed staffing needs with the executive leadership team, who then identified hiring priorities.

In discussions about the facility's unique attributes, the Director discussed challenges created by its size and complexity, with two large inpatient sites about 50 miles apart, and an outpatient

[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*.

clinic that serves over 55,000 veterans in the Jacksonville area, which is about 75 miles away from the main facility in Gainesville. According to the Director, the Jacksonville clinic is larger than a third of the VA facilities across the country. Rather than spreading the leadership team across such a large area, leaders said they expanded the team by adding deputy directors at each of the three major locations.

The Director also said the facility experienced hurricanes annually and served as a patient evacuation location for other VA medical facilities in the region. The OIG found leaders to be aware of the system's culture and how system shocks and unique circumstances affected it, taking appropriate actions in response.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[19] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[20] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[21] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[22]

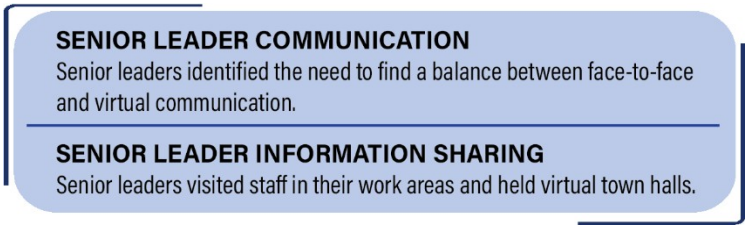


Figure 5. *Leader communication with staff.*
Source: OIG interview.

The facility's VA survey scores increased from FY 2021 to FY 2023. Leaders discussed speaking with staff during rounds (visits to staff in work areas) and having open conversations that included questions about leaders' communication and whether it was clear. The Director said leaders held virtual town halls during the COVID-19 pandemic but discontinued them because only 40 to 50 people were signing in. However, during rounds, a staff member told the

[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.

Director that sometimes what looked like one person signing in could be a team room with several people. Following this input, leaders reinstated regular town halls.

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

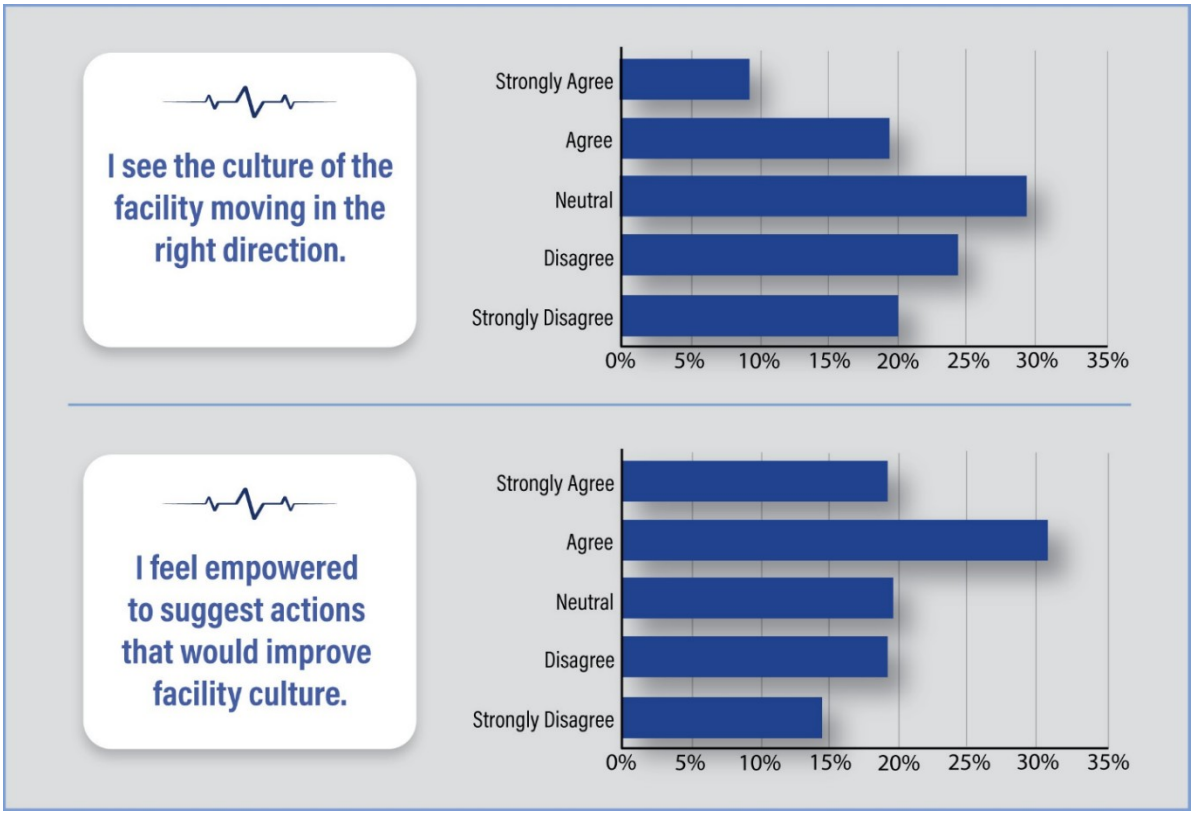


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

[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.

VA survey scores related to employees' perceptions about best places to work, fear of reprisal, supervisor trust, and psychological safety increased from FY 2021 to FY 2023. In the OIG's questionnaire, most respondents indicated they stayed at the facility due to pay and benefits, with VA's mission being the second highest response.

Questionnaire responses revealed stress and burnout as reasons employees would consider leaving the facility. During an interview, leaders said they believed employees were generally happy to work at the facility and were committed to its mission.

The Deputy Chief of Staff acknowledged areas of stress. For instance, nurses and some providers had heavy workloads due to insufficient staffing, and the VA struggled to compete with private sector salaries. The Director stated leaders had planned to create an Employee Experience Office that included a chief wellness officer the previous year; however, because of the new national staffing guidelines, they decided not to implement the plan. Leaders said they established an open door policy and listened to employees' concerns. The Director added that a Veterans Integrated Service Network psychologist was available to serve as a resource for employees if needed.[25]

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[26] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[27] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

During an interview, senior leaders indicated they met with local VSOs in person on a quarterly basis and offered virtual options for those who were unable to meet face-to-face. The leaders stated they also had informal conversations with VSO representatives to discuss specific issues. Additionally, the leaders shared that patient advocates addressed veterans' concerns and coordinated with staff to respond to issues as needed. Patient advocates also helped leaders identify trends in veterans' concerns. For example, several veterans reported concerns about the lack of wheelchairs at the entrances. Facility staff developed a process for corralling wheelchairs to ensure they are at every major entrance.

[25] 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/.

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

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[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 7. *Facility photo.*
Source: "Malcolm Randall Department of Veterans Affairs Medical Center," Department of Veterans Affairs, accessed February 5, 2025, https://www.va.gov/north-florida-health-care/locations/.

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]

[28] VHA Directive 1608(1).

[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.

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.

Veterans could arrive at the facility via public transit buses, and according to staff, the Disabled American Veterans VSO and VHA–Uber Health Connect Initiative sometimes provided transportation.[31]

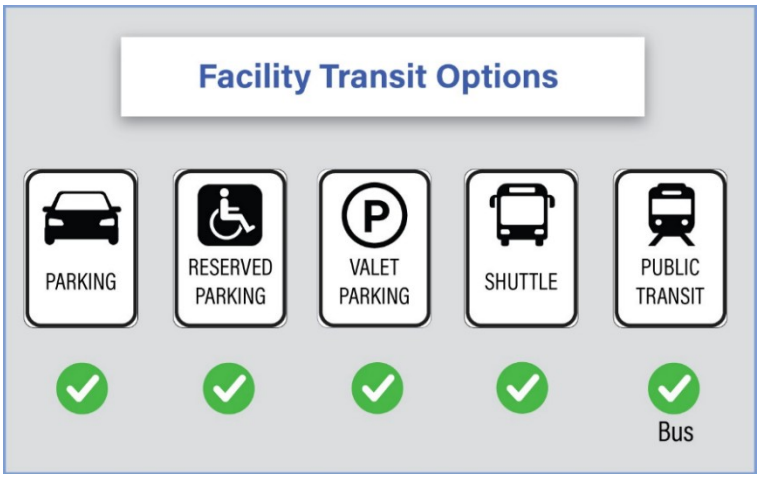


Figure 8. *Transit options for arriving at the facility. Source: OIG analysis of documents and interviews.*

The OIG accessed the facility's public website to obtain travel information to the facility. The OIG inspection team followed the website's directions, Google, and iPhone maps to reach the facility and found the instructions easy to follow. The OIG determined the parking area had lighting, emergency call boxes, and an adequate number of spaces, including spaces accessible for those with disabilities. During the day, volunteers circulated through the parking area in a golf cart to pick up veterans and take them to the main building. The facility also had valet parking and shuttle service to transport veterans to their locations.

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.[32]

The OIG noted the main entrance was marked by signage and had a passenger loading zone with a canopy for shelter, power-assisted doors with wheelchair ramps, and information desk staff to direct veterans to their locations. The main entrance was well lit and welcoming, with seating and a coffee shop selling refreshments. The facility also had volunteers who offered free coffee to veterans

Figure 9. *Basement entrance. Source: Photo taken by OIG inspector.*

[31] The VHA–Uber Health Connect Initiative is a partnership between VHA and Uber to provide veterans with transportation to and from medical appointments. "What is the VHA–Uber Health Connect (VUHC) Initiative?," Department of Veterans Affairs, accessed July 18, 2024, https://www.innovation.va.gov/VHA-Uber-Health.pdf.

[32] 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*.

in the morning. The entrance did not have wheelchairs, but staff were able to access them quickly when needed.

The OIG observed the parking areas and shuttle stops directed veterans through a basement entrance instead of the main entrance. The basement entrance was functional but visually less appealing than the main entrance and lacked space for veterans to socialize.

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.[33]

The OIG noted printed facility maps were available at the information desks in both the main and basement entrances, and both had staff to direct or escort veterans to their destination. The Chief of Environmental Management Services stated the facility was also implementing a combination wayfinding and signage project, which will add new signs throughout the facility.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[34] The OIG determined information desk staff were able to access interpreter services to communicate in sign language. The OIG observed sound-absorbing panels on the walls and noted the environment was quiet, which facilitated communication.

The Chief of Environmental Management Services stated the new signage project did not include braille at hallway intersections, which may increase visually impaired veterans' difficulty navigating the facility. The OIG encourages facility leaders to review VA

Figure 10. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG observations and staff commentary.

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

[34] 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.

interior design guidelines and best practices to ensure sensory-impaired veterans can safely and easily find their way around.

Toxic Exposure Screening Navigators

VA recommends 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.[35] The Toxic Exposure Screening Navigator said the program had adequate staff and resources to screen veterans during scheduled or walk-in appointments. The navigator also said staff advertised the screening program at multiple veteran-centered community events, and health fairs at community-based outpatient clinics.[36] At the time of the inspection, program data showed few veterans were overdue for screenings.

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.[37] 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.

During the physical inspection, the OIG found five issues that The Joint Commission also identified in a September 2022 accreditation report:

- Biomedical equipment stickers on cardiac monitors indicated preventive service was overdue, which could harm patients or delay care if the equipment malfunctions during use. The Joint Commission requires staff to conduct and document maintenance, inspection, and testing of all medical equipment.[38] This finding was also one of the top ten deficiencies identified in the facility's environment of care annual report for FY 2023. The OIG recommends the Associate Director of Operations ensures staff maintain, inspect, and test medical equipment.

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

[36] VetFest was an August 2023 event that allowed veterans and their families to explore various VA services available including toxic exposure screening. "VetFest Florida," Department of Veterans Affairs, accessed July 1, 2024, https://www.va.gov/outreach-and-events.

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

[38] The Joint Commission, *Standards Manual,* E-dition*,* EC.02.04.03, January 1, 2022.

- Staff did not secure medications from unauthorized access. The Joint Commission requires staff to safely store medications.[39] Also, VHA states that "access to medications must be limited to those individuals approved by the VA medical facility."[40] Unauthorized access to medications can lead to inappropriate use and cause harm to patients or staff. The OIG recommends the Deputy Chief of Staff ensures staff secure all medications from unauthorized access.
- Staff did not separate used oxygen storage tanks from full tanks ready for patient use, which could delay staff's administration of oxygen in an urgent situation. The Joint Commission requires facilities to have full and empty tanks separated from each other.[41] The OIG recommends the Associate Director of Patient Care Services ensures staff appropriately store oxygen tanks.
- Various patient food storage areas were dirty. The Joint Commission requires staff to store food and nutrition products using proper sanitation.[42] Allowing food storage areas to remain dirty may spread pathogens, such as bacteria and mold to patients and staff. The OIG recommends the Associate Director ensures staff clean all food storage areas.
- A storage room contained expired supplies. The Joint Commission requires staff to implement infection prevention and control procedures when storing medical supplies.[43] Supplies used past the date that manufacturers suggest could have degraded packaging or reduced quality. The OIG recommends the Associate Director of Operations ensures staff remove expired supplies from storage areas.

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 observed that common areas, such as hallways and waiting areas, appeared clean and well maintained. However, the OIG found three environment of care deficiencies, in addition to those discussed in the previous section.

[39] The Joint Commission, *Standards Manual,* E-dition, MM.03.01.01, January 1, 2022.

[40] VHA Directive 1108.07(2), *General Pharmacy Service Requirements*, November 28, 2022, amended December 6, 2024.

[41] The Joint Commission, *Standards Manual,* E-dition*,* EC.02.05.09, January 1, 2022.

[42] The Joint Commission, *Standards Manual*, E-dition, PC.02.02.03, January 1, 2022.

[43] The Joint Commission, *Standards Manual,* E-dition*,* IC.02.01.01, January 1, 2022.

The OIG found staff did not label broken equipment and therefore had no way to tell which equipment was available for use. The Joint Commission requires hospital staff to establish and maintain a "safe, functional environment."[44] The Chief of Facility Management said the facility lacked space to store the broken equipment, so staff placed it in an available room and often forgot or were too busy to attach repair tags.

The OIG also observed that clean storage areas contained dirty and damaged items and equipment. The Deputy Director said leaders were unaware staff stored dirty items in the clean storage areas. The OIG also noted that patient care areas were dirty, some had damaged walls with chipped or peeling paint, and the medication room had exposed piping. Dirty patient areas may cause the spread of illness to patients and staff. The infection preventionist and Chief of Environmental Management Services expressed the Environmental Management Services team has challenges with staffing and coordinating with nursing staff to gain access to clean some areas, such as the medication room. The OIG recommends the Associate Director of Operations ensures staff mark equipment that needs repair and separate it from equipment available for use and remove dirty items from clean storage areas.

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.[45] 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.[46] 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.

[44] The Joint Commission, *Standards Manual,* E-dition, EC.02.06.01, January 1, 2022.

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

[46] 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.

The OIG determined the facility had processes for staff to communicate abnormal test results to ordering providers, identify a surrogate provider when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours when needed. The OIG also noted staff performed scheduled internal audits that included a review of communication of test results to patients.

Providers usually receive test result notifications by view alerts in electronic health records. If providers receive an excessive number of notifications, they may experience alert fatigue and "become desensitized to safety alerts, and as a result, ignore or fail to respond appropriately to such warnings."[47] Facility leaders said alert fatigue was an ongoing challenge for providers due to the volume of alerts received. In the same interview, the OIG learned that service leaders had limited view alerts to only test results that required additional action from providers.

Action Plan Implementation and Sustainability

Figure 11. *Status of prior OIG recommendations. Source: VA OIG report.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[48] 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 did not find any open recommendations from the previous three years. However, during this inspection, the OIG found multiple issues that were also found in the 2022 Joint Commission inspection, as discussed in the Repeat Findings section above. The OIG also noted the External Survey/Survey Readiness Committee did not report action plans to assess sustained compliance with Joint Commission accreditation standards to the Executive Leadership Board. VHA requires medical facilities to comply with "Joint Commission accreditation standards and process requirements through implementation of a facility continuous compliance program."[49]

The Acting Chief of High Reliability said quality management staff recently presented the Executive Leadership Board with a plan that incorporated how they would review Joint

[47] "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

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

[49] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

Commission standards and ensure compliance. The OIG recommends facility leaders ensure sustained compliance with Joint Commission accreditation standards.

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.[50] 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.[51] 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 Acting Chief of High Reliability reported the newly hired External Peer Review Program Coordinator was currently receiving training on the program.[52] The Chief of Staff reported several methods leaders were employing to identify opportunities for improvement. For example, primary care staff conducted chart audits to assess whether providers acknowledged tests results and communicated them to the patient within the expected time frame.

The OIG found staff had implemented a rapid process improvement event where a team developed action plans to improve the quality of care for patients with heart failure.[53] The action plans focused on three key areas to improve: patient handoff, discharge education, and post-discharge follow-up. The OIG reviewed data that demonstrated an increase in post-discharge follow-up and a decrease in readmission rates.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[54] 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.

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

[51] VHA Directive 1050.01(1).

[52] The External Peer Review Program supports "review of identified medical records to assess the quality of both inpatient and outpatient care" at VA facilities. "External Peer Review Program (EPRP)," VHA Office of Informatics and Analytics, March 15, 2022, https://department.va.gov/EPRP.pdf. (This website is not publicly accessible.)

[53] Heart failure develops when the muscles of the heart do not function effectively, causing fluid build up in the lungs and shortness of breath. "Heart Failure," Mayo Clinic, accessed December 30, 2024, https://www.mayoclinic.org/heart-failure.

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

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.[55] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[56] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the visit, facility leaders told the OIG there were vacancies in primary care provider, registered nurse, clinical associate, and administrative associate positions. Primary care and facility leaders stated that primary care workload, budget constraints, and challenges competing with higher pay at Orlando VHA facilities and the private sector affected recruitment and retention of staff. Additionally, the facility served both urban and rural locations, which created challenges in some areas. For example, one rural site in Valdosta, Georgia, had a provider vacancy for several years due to lack of applicants, despite efforts to recruit eligible candidates.

To address vacancies, primary care leaders said they offered recruitment and retention incentives, including loan repayment, special salary rates, and flexible schedule options. However, leaders said the hiring process often exceeded six months for some positions, causing the loss of qualified candidates to other opportunities. Leaders added that they are actively engaged with Veterans Integrated Service Network 8 and human resources staff to address the hiring challenges.

In addition to staffing shortages, demand for care in some areas exceeded capacity due to space issues. For example, leaders expected the recently opened clinic in North Jacksonville, Florida, to need additional primary care teams, but its space was insufficient to accommodate additional staff.

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.[57] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[58]

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[55] 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).

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

[57] "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).

[58] VHA Directive 1406(1).

Primary care leaders shared that panel sizes were generally reasonable; however, leaders believed current allotted lengths for patient care appointments did not accommodate additional administrative tasks and clinical responsibilities of providers and staff.[59] Primary care team members also expressed concerns related to workload and expectations to deliver quality care while managing administrative tasks, such as responding to view alerts, answering secure messages from patients, and completing clinical reminders.[60] Primary care leaders were aware of staff's concerns and worked to address workload. For example, leaders regularly reviewed and adjusted provider panels to keep the number of assigned patients balanced across the teams and ensure patients had timely access to care.

Additionally, the leaders described meeting with the informatics team regularly to identify and implement more efficient ways to manage clinic demands, such as programmed shortcuts to streamline clinical documentation, and primary care staff found the efforts generally helpful. Nursing leaders also said staff assist other primary care teams by responding to secure messaging with patients, which helps balance workload.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[61] 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.

In interviews, facility and primary care leaders shared projects initiated to improve patients' access to care and reduce wait times. Primary care leaders reviewed provider panels and schedules and maximized provider availability and increased dedicated new patient appointments. Primary care leaders also described an ongoing project to automate the patient communication mailing process, which will reduce the time needed for administrative staff to print, fold, and mail letters and improve efficiency. Primary care team members explained they share ideas, concerns, and feedback in primary care team huddles and monthly meetings to increase communication within and among teams.

[59] "It is VHA policy that a minimum of 80% of a provider's total outpatient clinically mapped time worked is bookable for in-person, telephone, or telehealth care to ensure Veterans' access to care." VHA Directive 1231(4), *Outpatient Clinic Practice Management*, October 18, 2019, amended February 7, 2024.

[60] Clinical reminders "can direct providers to perform certain tests or other evaluations that will enhance the quality of care for specific conditions." Department of Veterans Affairs, Office of Information and Technology, *Clinical Reminders Manager's Manual,* March 2005, revised September 2022.

[61] VHA Handbook 1101.10(2).

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 the facility's veteran enrollment increased from FY 2022 to FY 2023. Primary care leaders attributed the increase, in part, to population growth in the service area. Primary care leaders analyzed demand for care, patient panels, staffing, and space to anticipate and meet future needs. Primary care providers told the OIG that toxic exposure screenings added time to appointments because they had to address veterans' concerns about exposures, clinical symptoms, and potential future health conditions. Primary care leaders anticipated this workload would decrease as future screenings became more focused on veterans who previously reported toxic exposures.

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[62]

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).[63] 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."[64]

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

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

[64] 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.

The program did not meet the HCHV5 target for FYs 2022 through 2023. Program staff attributed this shortfall to community partners preventing staff from entering shelters to perform outreach due to the pandemic, staffing vacancies, and veterans who have turned down multiple efforts to engage in the program.

HCHV program staff reported they identify and enroll veterans through community outreach (connecting to veterans through community-based agencies) and street outreach (making direct contact with unsheltered veterans). Outreach staff located throughout the facility's large service area conduct community outreach by video and telephone, or in person at community agencies and meetings with community partners. Program staff also work in shifts to return homeless hotline calls to veterans in need of assistance and enroll them in the program, if possible. Facility leaders and program staff participated in homeless stand-downs and point-in-time counts.[65]

OIG questionnaire respondents indicated they participated in a University of Florida grant-funded pilot program to establish trust and rapport with homeless veterans. As part of the program, a psychiatrist, outreach staff member, and community outreach staff conducted street outreach at least three times per month for three to four hours each day in the Gainesville area. Program staff indicated the effort had proven invaluable, especially for homeless veterans with mental health issues who were not eligible to receive VA healthcare benefits but were able to receive prescribed psychotropic medications at no cost through the university program. The next two scheduled locations for the outreach program are Jacksonville and Ocala.

[65] "Stand Downs are an outreach strategy to engage homeless Veterans and present them with longer-term treatment and housing opportunities. The 1- to 3-day events provide homeless Veterans a temporary refuge where they can obtain food, housing assistance, supplies and a range of community and VA assistance. In many locations, Stand Downs provide health screenings, referral and access to housing and treatment services, benefits counseling, ID cards and access to other programs to meet a Veteran's immediate needs." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services*, February 18, 2022.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[66]

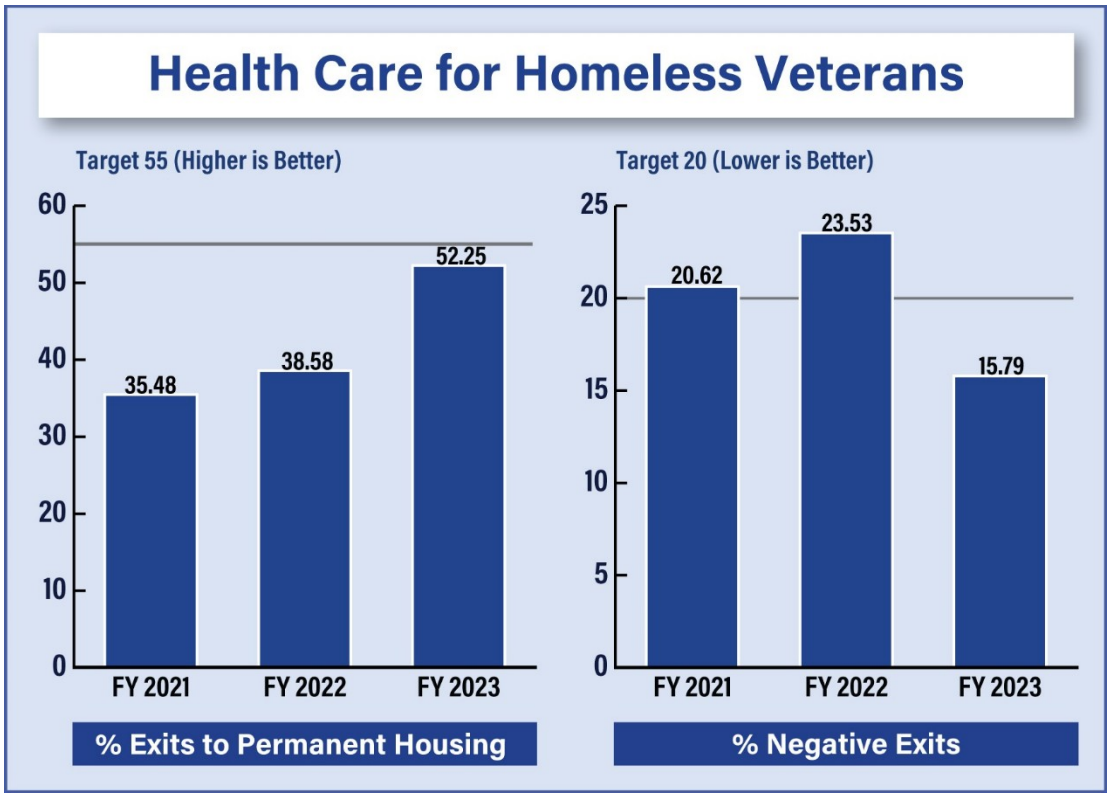

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

At the time of the OIG site visit, staff stated the program had two contracted residential facilities, one in Gainesville and the other in Jacksonville, Florida. Staff reported they were able to get veterans into the contracted facilities easily because they had few admission requirements. However, they noted there were other housing options better suited to some veterans but not classified as permanent, such as apartment-like housing where they live together and cook meals. Staff explained that placing veterans into these alternative housing options negatively affected the program's ability to meet the HCHV1 target. An additional barrier to meeting the HCHV1

[66] 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*.

target were veterans needing a higher degree of care than staff could provide through contracted facilities.

To explain missing the HCHV2 target, program staff reported some veterans left contract housing due to substance use; those not yet in treatment may have struggled with following rules and left; and others trying to recover from substance use may have left after being in close contact with substance abusers in the area. Program staff conduct unscheduled inspections and visit with veterans weekly to ensure they are progressing toward their goals and to address any concerns.

Staff said they enroll veterans in case management to ensure continuity of care until they are able to enroll in a housing program. Program leaders established an interdisciplinary team across the facility's homeless services. The HCHV program had dietitians, occupational therapists, vocational rehabilitation experts, and mental health providers aligned under the Associate Chief of Staff, Mental Health, allowing veterans to receive care through the program until staff could enroll them in primary care services.

For homeless inpatients, program staff reported they collaborate with care teams to determine safe discharge plans. HCHV program staff said they create and distribute a weekly census document listing the availability of beds at contract housing programs and the on-site residential treatment facility, so providers who might encounter homeless veterans while providing medical or mental health care could refer them to the program when beds are available.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[67] 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.[68]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[69] The program did not meet the performance measure target for FY 2023. Program staff said they misunderstood when to complete entry forms, which they had been doing only when working with veterans on a long-term basis. After program leaders

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

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

[69] 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*.

educated staff about the expectation to complete entry forms for every person contacted, the program was on track to meet the target for FY 2024.

Program staff identify veterans through multiple methods: state prisons provide a list of incarcerated veterans, and law enforcement personnel, court staff, family members, healthcare providers, and other facility homeless program staff refer veterans who are incarcerated or soon to be. Program staff meet with veterans individually or in small groups to provide information on resources to help with assimilation back into the community.

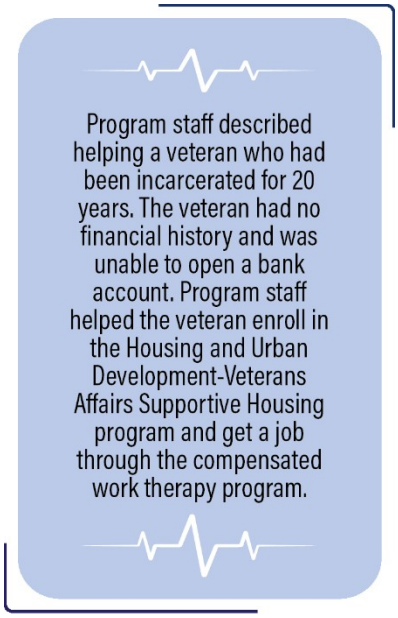

Figure 13. *Veterans Justice Program participant success story. Source: OIG interview.*

Meeting Veteran Needs

When initiating contact, program staff complete an initial assessment to determine veterans' needs. Staff then refer the veterans to facility programs, such as primary care, substance use disorder treatment, homeless services, and specialty mental health services, or match them with community partners. Veterans leave the program when they meet treatment goals or terminate their participation.

A program staff member described regularly partnering with and supporting 10 veterans treatment courts and additional treatment courts as needed.[70] Veterans treatment court personnel consider program staff's initial assessment and treatment goals, including enrollment in primary care, connection to mental health services if needed, and assistance locating stable housing, when determining treatment plans for veterans. Staff engage veterans to identify their individual goals, in addition to court requirements. Program staff said that being aligned under the mental health service was an advantage for coordinating care for enrolled veterans as it was easier to schedule mental health appointments.

A staff member highlighted working closely with VA Police and local law enforcement to provide crisis intervention training to frontline officers and collaborating with community law enforcement teams to identify and intervene with veterans who were exhibiting behaviors that, if escalated, could lead to arrest.

[70] 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.

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."[71] 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.[72]

Identification and Enrollment of Veterans

VHA's Housing and Urban Development–Veterans Affairs Supportive Housing program targets are based on point-in-time measurements, including the percentage of housing vouchers assigned to the facility that are being used by veterans or their families (performance measure HMLS3).[73] The facility's program did not meet the target for FYs 2021 through 2023. Program staff cited staffing vacancies and a lack of affordable housing as reasons for low voucher use. Program staff reported they lost staff during the pandemic, but vacancies decreased after facility leaders implemented a special salary rate for the positions in July 2023.

Program staff indicated that another barrier to finding affordable housing for veterans was that developers focused on building luxury complexes for student housing in cities with large universities, such as Tallahassee and Gainesville, which increased rental rates above the voucher limits. Program staff engage with local landlords by conducting fairs in Tallahassee, Jacksonville, and Gainesville, as well as hosting events with refreshments to demonstrate appreciation to landlords.

Program staff also participate in stand-downs and attend weekly or monthly meetings with local housing authorities to discuss voucher use. Staff explained the facility serves a large area and they communicate with eleven housing authorities, each with their own business rules, administrative plans, and payment standards, making the work challenging.

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

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

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

[73] 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*.

percentage of veterans employed at the end of each month (performance measure VASH3).[74] The OIG found the facility program exceeded the target for FY 2023. Program staff said they increased staffing and expanded the Compensated Work Therapy program to new locations, creating additional jobs for homeless veterans.[75]

Program staff discussed one of their challenges in meeting veterans' housing needs as locating appropriate housing for elderly veterans who cannot live independently. Staff use creative practices to meet the challenges of the aging veteran population. For example, veterans can use housing vouchers in group homes, nursing homes, and assisted living facilities, and staff refer veterans to facilities such as Veterans Village in Fort McCoy, Florida, a Veterans of Foreign Wars home that accepts vouchers and provides private rooms, meals, transportation, entertainment, and laundry services. Facility staff also provide healthcare services to veterans on-site at Veterans Village so they do not have to travel to the local clinic. Program staff also established the Silver Elite Team, which consists of a social worker, peer support staff, nursing staff, and occupational therapists, to support veterans who are at high risk of homelessness with case management to ensure they maintain housing.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

[74] 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*.

[75] "Compensated Work Therapy (CWT) is a Department of Veterans Affairs (VA) clinical vocational rehabilitation program that provides evidence based and evidence informed vocational rehabilitation services; partnerships with business, industry and government agencies to provide Veteran candidates for employment and Veteran labor, and employment supports to Veterans and employers." "Compensated Work Therapy," Department of Veterans Affairs, accessed September 12, 2024, https://www.va.gov/health/cwt/.

OIG Recommendations and VA Response

Finding: Biomedical staff did not perform preventive service on medical equipment according to schedule.

Recommendation 1

The OIG recommends the Associate Director of Operations ensures staff maintain, inspect, and test medical equipment.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

Biomedical Engineering Service Chief ensures maintenance, inspection, and testing of medical equipment in accordance with manufacturer requirements. Equipment is labeled with an inspection sticker that indicates that appropriate inspection, testing, and maintenance have been conducted. Biomedical Engineering Service Chief or designee will conduct periodic audits to ensure equipment has a current inspection sticker indicating that appropriate testing and maintenance have been performed. Periodic audits of equipment will demonstrate six consecutive months of 90% compliance with current inspection stickers. The Biomedical Engineering Service Chief or their designee will report compliance to The Safety and Health Leadership Committee.

Finding: Staff did not secure medications from unauthorized access.

Recommendation 2

The OIG recommends the Deputy Chief of Staff ensures staff secure all medications from unauthorized access.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

The Chief of Pharmacy or designee will conduct periodic observations in the clinical areas to ensure the securement of medications from unauthorized access. Periodic observations by the Chief of Pharmacy or designee will demonstrate six consecutive months of 90% compliance with

securing medications from unauthorized access. The Chief of Pharmacy or designee will report compliance to The Pharmacy and Therapeutics Committee.

Finding: Staff did not separate used oxygen storage tanks from full tanks ready for patient use, which could delay staff's administration of oxygen in an urgent situation.

Recommendation 3

The OIG recommends the Associate Director of Patient Care Services ensures staff appropriately store oxygen tanks.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

In July 2024, Joint Commission tracers were implemented utilizing Tracers with AMP, which includes inspection of oxygen storage per regulatory standards. Additional tracers by the Supervisor of Respiratory Services or designee will be conducted on oxygen storage tanks to ensure appropriate storage per standards at 90% compliance for six consecutive months. Compliance will be reported to the Health Operations Council (HOC) by the Supervisor of Respiratory Services or designee.

Finding: Various food storage areas were dirty.

Recommendation 4

The OIG recommends the Associate Director ensures staff clean all food storage areas.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

The Environmental Management Services (EMS) Management and the Food Services Management observe food storage areas to ensure cleanliness; they take immediate action to ensure ongoing cleanliness.

The Chief of EMS and the Chief of Food Service or their designee will conduct periodic rounds to achieve 90% compliance to cleanliness for six consecutive months. Compliance will be reported to the HOC by the Chief of EMS or their designee.

Finding: A storage room contained expired supplies.

Recommendation 5

The OIG recommends the Associate Director of Operations ensures staff remove expired supplies from storage areas.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

The Chief of Supply Chain or their designee conducts random, unannounced reviews of Medical Supply Storage Quality Assurance Check sheets weekly to demonstrate compliance with removing expired supplies from storage areas. The Medical Supply Storage Quality Assurance Check sheets are completed to verify all expired supplies have been removed from storage areas. The Chief of Supply Chain or their designee will ensure Medical Supply Storage Quality Assurance Check Sheets are completed to demonstrate 90% compliance for six consecutive months and will report compliance to the HOC.

Finding: Staff did not label broken equipment, and clean storage areas contained dirty and damaged items and equipment.

Recommendation 6

The OIG recommends the Associate Director of Operations ensures staff mark equipment that needs repair and separate it from equipment available for use and remove dirty items from clean storage areas.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

The Chief of EMS will ensure environmental care rounds and/or tracers are conducted to ensure compliance with tagging equipment that needs repair and/or is dirty and that it is segregated from clean equipment storage. Posters will be developed by the Chief of EMS or their designee and mounted for staff instruction on appropriate equipment storage, tagging, and clean versus dirty equipment segregation. Periodic rounds and/or tracers by the Chief of EMS or their designee will

demonstrate 90% compliance over six consecutive months to appropriate tagged equipment and storage. Compliance will be reported to the HOC by the Chief of EMS or their designee.

Finding: Facility leaders did not ensure an ongoing review to assess compliance with Joint Commission standards as evidenced by multiple repeat issues found in the 2022 Joint Commission Inspection.

Recommendation 7

The OIG recommends facility leaders ensure sustained compliance with Joint Commission accreditation standards.

__X__ Concur

____ Nonconcur

Target date for completion: August 31, 2025

Director Comments

NF/SGVHS assesses sustained compliance with The Joint Commission (TJC) through tracer methodology and environment of care rounds. TJC readiness is prioritized and aligned with the Safer Matrix defined in the TJC tri-annual accreditation survey. A Joint Commission Readiness Workgroup and Plan was developed to ensure TJC readiness. The plan consists of TJC standards presentations by subject matter experts, tracers, observations, and readiness monitoring. Ongoing readiness is assessed using Tracers with AMP, by which tracers are completed. Findings are gathered and disseminated to department leaders for follow-up and resolution. Compliance with TJC tracers are reported to the Health Operations Council (HOC) and other councils as deemed appropriate. The report is provided by the Chief of The Office of High Reliability. The HOC and other councils/committees noted herein cascade to the Executive Leadership Council for review and action.

Executive Leadership Council monthly meeting minutes will reflect TJC readiness % of compliance to action items.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to VSOs.[2] 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.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from June 4 through 6, 2024. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

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

[2] The OIG did not receive any responses to the questionnaire.

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

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] 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.

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 31, 2025

From: Network Director, VISN 8 (10N8)

Subj: Initial Response–Healthcare Facility Inspection of the North Florida/South Georgia Veterans Health System in Gainesville, Florida (Draft Report)

To: Director, Office of Healthcare Inspections (54HF01)

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

1. I have reviewed the response provided by the Executive Director of the North Florida, South Georgia VA Healthcare System (NFSG), Gainesville, Florida. I concur with the response.
2. If you have additional questions or need further information, please contact the VISN 8 Quality Management Officer.

(Original signed by:)

David Isaacks, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: March 25, 2025

From: Executive Health System Director, North Florida/South Georgia Veterans Health System, Gainesville, FL (573/00)

Subj: Healthcare Facility Inspection of the North Florida/South Georgia Veterans Health System in Gainesville

To: Network Director, VISN 8 (10N8)

1. I appreciate the Office of Inspector General's recommendations and look forward to closing them in a timely manner. Thank you for the opportunity to partner in continuous process improvement activities in the delivery of care to our Veterans.
2. We are committed to ensuring the highest quality, efficient and compassionate care to those we are honored and privileged to serve. Our mission in the VA reminds us all how important it is to strengthen our efforts in continuous improvement.
3. If you have additional questions or need further information, please contact the North Florida/South Georgia Veteran's Health System's Chief Nurse, Office of High Reliability.

(Original signed by:)

Wende K. Dottor

OIG Contact and Staff Acknowledgments

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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.