US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Orlando Healthcare System in Florida

Healthcare Facility Inspection	24-00585-246	September 24, 2024

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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 a cyclical review program called Healthcare Facility Inspections. The Healthcare Facility Inspections team reviews 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 inspected the VA Orlando Healthcare System (facility) during the week of February 12, 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 reviewed the facility's culture across multiple dimensions, including unique circumstances and system shocks (disruptive events affecting healthcare operations), leadership communication, workplace diversity, and both employees' and veterans' experiences. In an interview, executive leaders identified having to manage the highest number of COVID-19 patients in Veterans Integrated Service Network (VISN) 8 as a system shock. Leaders described responding to this system shock by increasing the number of operating beds on three inpatient units to accommodate patient demand. Although leaders decreased the bed levels to approved numbers on one unit at the end of the pandemic, bed levels remained above capacity on two of the units. Leaders increased staffing and resources to meet the patient demand; however, the rooms were not designed to be shared. The OIG noted that leaders had not followed VHA's process for modifying the number of beds in use. The OIG made a recommendation to address this issue.

The OIG also reviewed the results of the All Employee Survey and found the scores improved across various areas, including communication and information sharing, diversity, best places to

[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.

work, and supervisory trust and psychological safety.[2] The OIG administered a staff survey prior to the site visit and found the results largely mirrored the All Employee Survey. Staff reported leaders improved their communication efforts and information sharing was clear, useful, and frequent. Staff identified the VA mission as the main reason that kept them at the facility, and reported they felt empowered to make suggestions for further improvement. Staff were split on whether the culture of the facility was moving in the right direction.

Based on responses to OIG-administered questionnaires, Veteran Service Organizations and the facility's Patient Advocate reported that they could provide feedback to leaders about veteran care, and leaders were responsive to concerns.

Environment of Care

The OIG inspected several clinical and nonclinical areas and found the facility to be clean and well-maintained, with ample parking and a welcoming main entrance. 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.[3] During environment of care rounds, the OIG found that facility staff placed multi-lingual informational flyers at the facility's information desks to inform veterans of these new benefits and how to access more information.

The OIG also found the pneumatic tube system used to deliver medications in the locked dementia unit was unsecured and made a recommendation to resolve this vulnerability.

Patient Safety

The OIG examined the facility's patient safety processes by reviewing communication of urgent, noncritical test results to ordering providers, implementation of corrective action plans in response to oversight report recommendations, and development of initiatives for continuous process improvements. The OIG found staff regularly audited data related to provider notification of test results and the audits did not identify any major concerns or delays. Through interviews, the OIG learned that quality management staff monitored sustainment of corrective

[2] The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." AES [All Employe Survey] Survey History, Understanding Workplace Experiences in VA, VHA National Center for Organization Development. Psychological safety is the perceived ability to express one's thoughts and opinions without fear of negative repercussions. Barjinder Singh, Doan Winkel, and T.T. Selvarajan, "Managing Diversity at Work: Does Psychological Safety Hold the Key to Racial Differences in Employee Performance?," *Journal of Occupational and Organizational Psychology* 86, no. 2 (June 2013): 242–263, https://doi.org/10.1111/joop.12015.

[3] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022); The White House, "FACT SHEET: President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans," press release, August 10, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/.

actions, and leaders supported process improvement projects. At the time of the inspection, the facility had no open recommendations.

Primary Care

The OIG examined whether primary care teams were staffed per VHA guidelines and received support from facility leaders. Although the facility had a shortage of nursing and administrative staff, the OIG found patients did not experience increased appointment wait times or delays in care because leaders reallocated staff to the primary care clinics that had shortages. To prepare for the increased patient enrollment due to the PACT Act, leaders created eight new primary care teams and established interim care clinics to provide primary care services to unassigned, traveling, and walk-in patients, which reduced appointment wait times to less than 20 days. Primary care team members reported feeling supported by facility leaders and that leaders were working to improve efficiency and team function.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development-Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and assess how well the programs meet veterans' needs. The OIG found the facility had active homeless and Veterans Justice programs with a strong emphasis on outreach services and connections with multiple community partners. However, the Homeless Program Coordinator identified two barriers in meeting veterans' needs: transportation and affordable housing. The public bus system was inefficient across the six counties served and rideshare benefits for unscheduled appointments were no longer available. Affordable housing is limited in accessible locations, which results in veterans moving to more remote and isolated areas. In response, staff were working with veterans and housing authorities to consider alternative options, including shared housing and extended stay hotels.

What the OIG Recommended

The OIG made two recommendations.

1. The Facility Director works with Veterans Integrated Service Network leaders to reevaluate the current bed level capacity and submit the bed change request as required.
2. The Facility Director ensures that staff secure the pneumatic tube system to prevent unauthorized access to medications.

VA Comments and OIG Response

The Veterans Integrated Network and Facility Directors agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C, D, and E, pages 34–36 for the full text of the directors' comments). The OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH JR., M.D.
Assistant Inspector General
for Healthcare Inspections

Abbreviations

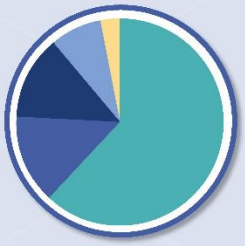
FY	fiscal year
HCHV	Health Care for Homeless Veterans
HRO	high reliability organization
OIG	Office of Inspector General
PACT	Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	veterans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

FACILITY IN CONTEXT

VA Orlando Healthcare System
Orlando, Florida
Level 1a-High Complexity Facility
Orange County
Hospital Referral Region: Orlando

Description of Community

RACE AND ETHNICITY



MEDIAN INCOME

$56,982

EDUCATION

89% Completed High School
59% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **312**

POPULATION

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

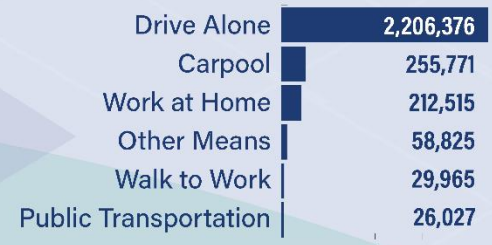
UNEMPLOYMENT RATE

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

SUBSTANCE USE

24.4% Driving Deaths Involving Alcohol
20.5% Excessive Drinking
2,472 Drug Overdose Deaths

TRANSPORTATION



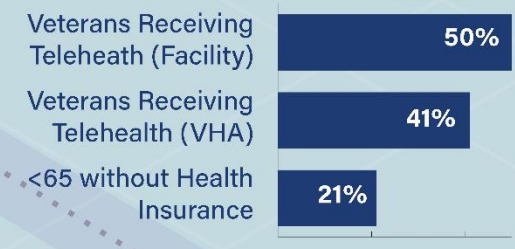
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**15 Minutes, 9.5 Miles**
Specialty Care	**49.5 Minutes, 46 Miles**
Tertiary Care	**92 Minutes, 92 Miles**

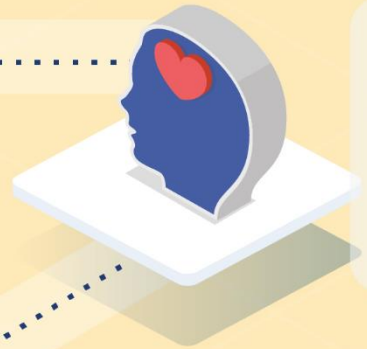
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients 62,598



Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

42,367

604 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.04 Days

30-DAY READMISSION RATE

12%

SUICIDE RATE PER 100,000

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

Health of the Facility

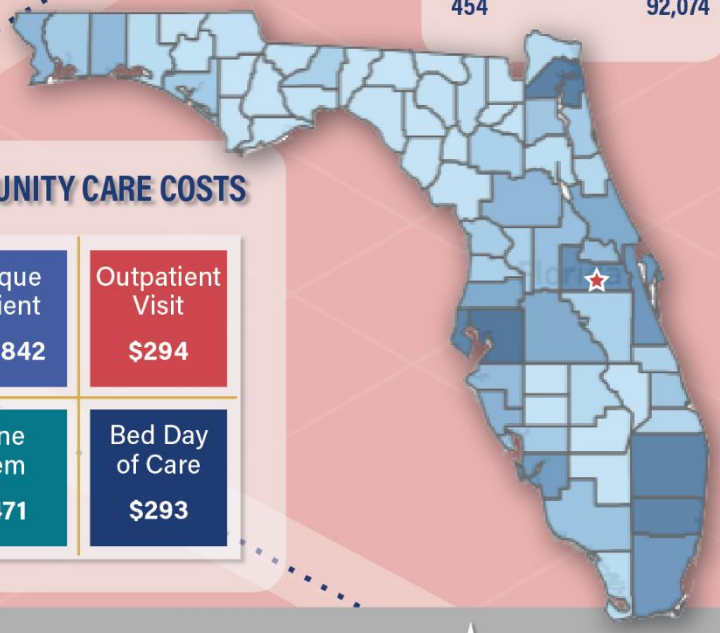
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	142K
Unique Patients VA Care	135K
Unique Patients Non-VA Care	56K

★ VA MEDICAL CENTER

VETERAN POPULATION

454 — 92,074



COMMUNITY CARE COSTS

Unique Patient $13,842	Outpatient Visit $294
Line Item $471	Bed Day of Care $293

STAFF RETENTION

Onboard Employees Stay <1 Yr	9.65%
Facility Total Loss Rate	11.11%
Facility Retire Rate	2.34%
Facility Quit Rate	8.42%
Facility Termination Rate	0.29%

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

Contents

Executive Summary i

What the OIG Found i

What the OIG Recommended iii

VA Comments and OIG Response iv

Abbreviations v

Background and Vision 1

High Reliability Organization Framework 2

PACT Act 3

Content Domains 4

CULTURE 5

System Shocks 6

Leadership Communication 7

Workplace Diversity 8

Employee Experience 10

Veteran Experience 11

ENVIRONMENT OF CARE 12

Entry Touchpoints 12

Toxic Exposure Screening Navigators 15

Repeat Findings....15
General Inspection....16
PATIENT SAFETY....17
Communication of Urgent, Noncritical Test Results....17
Action Plan Implementation and Sustainability....18
Continuous Learning through Process Improvement....18
PRIMARY CARE....19
Primary Care Teams....19
Leadership Support....20
The PACT Act and Primary Care....21
VETERAN-CENTERED SAFETY NET....21
Health Care for Homeless Veterans....21
Veterans Justice Programs....23
Housing and Urban Development-Veterans Affairs Supportive Housing....24
Conclusion....26
Summary of Findings and Recommendations....27
Minor....27
Appendix A: Methodology....28
Inspection Processes....28

Appendix B: Facility in Context Data Definitions 30

Appendix C: VISN Director Comments 34

Appendix D: Facility Director Comments 35

Appendix E: VA Responses 36

Recommendation 1 36

Recommendation 2 36

OIG Contact and Staff Acknowledgments 37

Report Distribution 38

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 a cyclical review program, called Healthcare Facility Inspections (HFI), 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

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

insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

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]

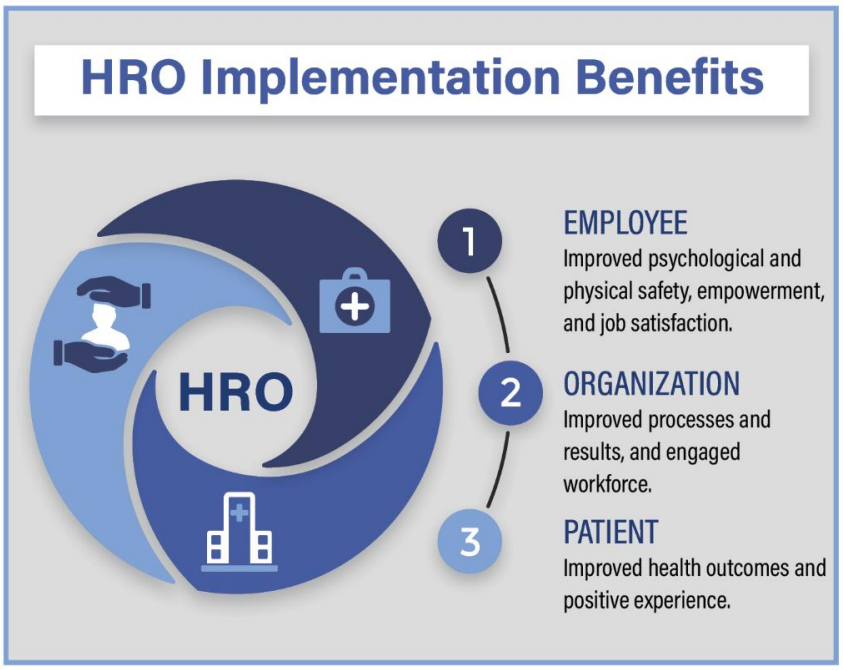


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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]

[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Stephanie Veazie, Kim Peterson, and Donald 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's 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.)

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all 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.

[7] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality.

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

[9] PACT Act, Pub. L. No. 117-168, 136 Stat. 1759 (2022); The White House, "FACT SHEET: President Biden Signs the PACT Act and Delivers on His Promise to America's Veterans," press release, August 10, 2022, https://www.whitehouse.gov/briefing-room/statements-releases/2022/08/10/fact-sheet-president-biden-signs-the-pact-act-and-delivers-on-his-promise-to-americas-veterans/.

[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," Department of Veterans Affairs, accessed May 1, 2023, https://www.accesstocare.va.gov/VA_PACTActDashboard.pdf.

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; Jeffrey 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, https://www.va.gov/HOMELESS/VA-Homeless-2022-HPO-Annual-Report-508c.pdf.

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 Orlando Healthcare System (facility) opened in 2006 and began providing inpatient services in 2015. At the time of the inspection, the facility's executive leaders consisted of a Medical Center Director (Facility Director), Chief of Staff, Associate Director for Patient Care Services, Deputy Director, Associate Director, and Assistant Director. The assistant director position was vacant. The newest member of the leadership team, the Associate Director, was assigned in July 2023. The Chief of Staff, assigned in January 2016, was the most tenured. In fiscal year (FY) 2023, the facility's budget was approximately $1.7 billion. The facility had 370 operating beds, including 134 hospital beds, 120 community living center beds, and 116 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, under developed, 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, workplace diversity, and both employees' and veterans' experiences. The OIG administered a facility-wide survey, reviewed VHA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

[13] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 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 July 15, 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.

[16] For more information on the OIG's data collection methods, see appendix A.

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.

In an interview, the facility's executive leaders discussed several system shocks that affected the organization's culture. The shocks included managing the highest number of COVID-19 patients in Veterans Integrated Service Network (VISN) 8 during the pandemic, coping with registered nurse staffing shortages, dealing with an unexpected water main break in the emergency department, and experiencing three hurricanes. The executive leaders described activating the medical center's incident command team, mobilizing nursing staff, and restructuring patient rooms by increasing the number of beds in rooms to meet demands caused by the shocks. The leaders further reported responding to the system shocks by maintaining visibility, communicating frequently, and implementing some staff requests, including flexible working hours and new Wellness rooms to support staff's mental health.

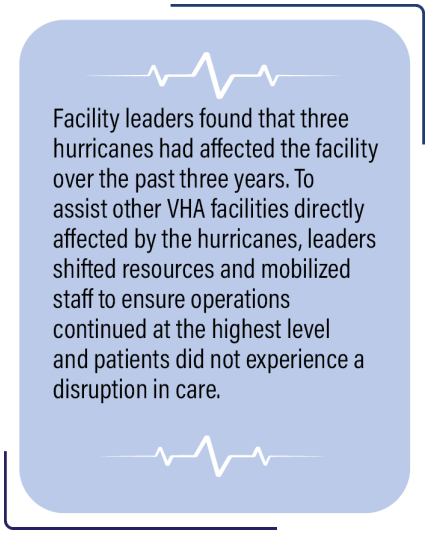


Figure 4. *Facility system shocks. Source: OIG analysis of interviews.*

Based on an interview with facility leaders, the OIG determined leaders responded to each of these system shocks. However, the OIG further found that leaders increased bed levels on three inpatient units above capacity to accommodate demand during the COVID-19 pandemic. Leaders reported decreasing bed levels on one unit and acknowledged that the other two units remained above capacity. Although the affected rooms can accommodate two patients and staffing and resources had been adjusted to meet the increased patient capacity, they were designed as single person rooms. VHA has a process when facilities need to modify the number

[17] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies."

[18] Valerie M. 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*.

of beds in use.[19] In a discussion with facility leaders at the end of the site visit, the OIG found leaders had not followed the process to increase the number of beds on the two units. The OIG recommended that the Facility Director work with VISN leaders to reevaluate the current bed level capacity and submit the bed change request as required.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] 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.[21] 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."[22]

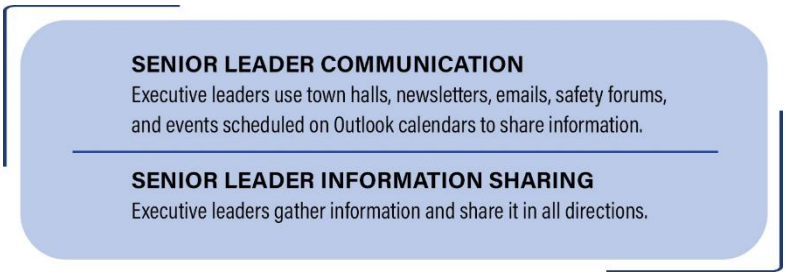


Figure 5. *Leader communication with staff.*
Source: OIG interviews with facility leaders.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[23] The facility's All Employee Survey scores for senior leaders' communication, information sharing, and transparency improved from FYs 2022 to 2023. During an interview, executive leaders expressed awareness of the All Employee Survey scores and described increasing their efforts to ensure open communication and transparency with all staff. The leaders reported engaging in tiered huddles to interact with employees, address their concerns, and ensure all staff receive the same information.[24] The executive leaders also mentioned using town halls, newsletters, emails, and safety forums to further maintain

[19] VHA Handbook 1000.01, *Inpatient Bed Change Program and Procedures*, December 22, 2010.

[20] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

[21] 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*.

[22] 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.

[23] 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.

[24] Tiered huddles, used from front-line staff to senior leaders, are brief, focused meetings used to share information, identify possible problems, address staffing levels, and allocate resources. Naseema B Merchant, et al., "Creating a Process for the Implementation of Tiered Huddles in a Veterans Affairs Medical Center," *Military Medicine* 188, no. 5-6 (May 16, 2023): 901-906, https://pubmed.ncbi.nlm.nih.gov/35312000/.

communication throughout the organization. However, leaders acknowledged staff may experience information overload as a barrier to communication; to address this, they keep emails short and ensure the most important information appears first. The OIG surveyed staff and found they largely agreed or strongly agreed that facility leaders made changes to how they communicate information, that these changes were an improvement, and the communicated information was clear, useful, and frequent.

Workplace Diversity

VHA defines diversity as "all that makes us unique," and has acknowledged a need to recruit a workforce reflective of society.[25] In addition to improving patient care outcomes through more accurate clinical decision-making, a diverse workforce can increase productivity and innovation.[26] Organizations with cultures that celebrate diversity and inclusion encourage self-expression and enhance psychological safety, part of the safety culture, which is foundational to an HRO.[27] Having workplace staff representative of the veterans and surrounding community can build trust, facilitate communication, and strengthen the relationship between the facility and veterans served.[28]

The OIG evaluated whether staff perceived facility leaders as inclusive and supportive of diversity. The OIG reviewed the facility's employment data and found the facility did not meet VA targets for veterans and individuals with disabilities (see figure 6).

Figure 6. *Facility workforce diversity.*
Source: OIG analysis of facility human resources data.

[25] The definition clarifies "unique" as "including but not limited to race, color, national origin, ethnicity, sex, sexual orientation, gender identity, religion, disability status, age and mutable characteristics such as educational background, socioeconomic status, organizational level, geographic region and cognitive/intellectual perspective." VA Directive 5975, *Diversity and Inclusion*, April 29, 2021.

[26] L.E. Gomez and Patrick Bernet, "Diversity Improves Performance and Outcomes," *Journal of the National Medical Association* 111, no. 4 (August 2019): 383–392, https://doi.org/10.1016/j.jnma.2019.01.006.

[27] Psychological safety is the perceived ability to express one's thoughts and opinions without fear of negative repercussions. Barjinder Singh, Doan Winkel, and T.T. Selvarajan, "Managing Diversity at Work: Does Psychological Safety Hold the Key to Racial Differences in Employee Performance?," *Journal of Occupational and Organizational Psychology* 86, no. 2 (June 2013): 242–263, https://doi.org/10.1111/joop.12015. Department of Veterans Affairs, *VHA HRO Framework*.

[28] Marcella Alsan, Owen Garrick, and Grant Graziani, "Does Diversity Matter for Health? Experimental Evidence from Oakland," *American Economic Review* 109, no. 12 (2019): 4071–4111, https://doi.org/10.1257/aer.20181446. "An inclusive environment enables Veterans and employees to feel safe, respected, engaged, motivated, and valued for who they are and their contributions toward organizational goals." Office of Health Equity, Veterans Health Administration, "Increasing Diversity in Recruitment and Advancement Across VA to Achieve Equitable Care and Outcomes," June 2023, https://www.va.gov/IncreasingVAWorkforceDiversity_June2023_FINAL.pdf.

In reviewing the All Employee Survey scores related to workplace diversity, the OIG noted that staff responses indicated they perceived diversity had improved from FYs 2022 to 2023. According to information staff provided to the OIG, the facility hosted 30 special emphasis events related to diversity and inclusion in calendar year 2023. The events focused on a federal women's program; sexual orientation and gender identity groups; and African American and Black, Native American, and Alaskan Native American employment programs. The executive leaders confirmed that staff participated in several of the special emphasis events, including a Hispanic heritage celebration, the Martin Luther King Jr. parade, pride events, and a women veterans tea party. The executive leaders described informing staff of events and encouraging participation via emails, social media, calendar invites, and overhead announcements. In addition, the leaders mentioned engaging in community outreach by meeting with Native American and other minority veteran groups to collaborate and advertise the special emphasis events. The OIG found that executive leaders were committed to prioritizing diversification efforts through collaboration, special emphasis events, and community outreach.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[29] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[30] The OIG surveyed employees and sought to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

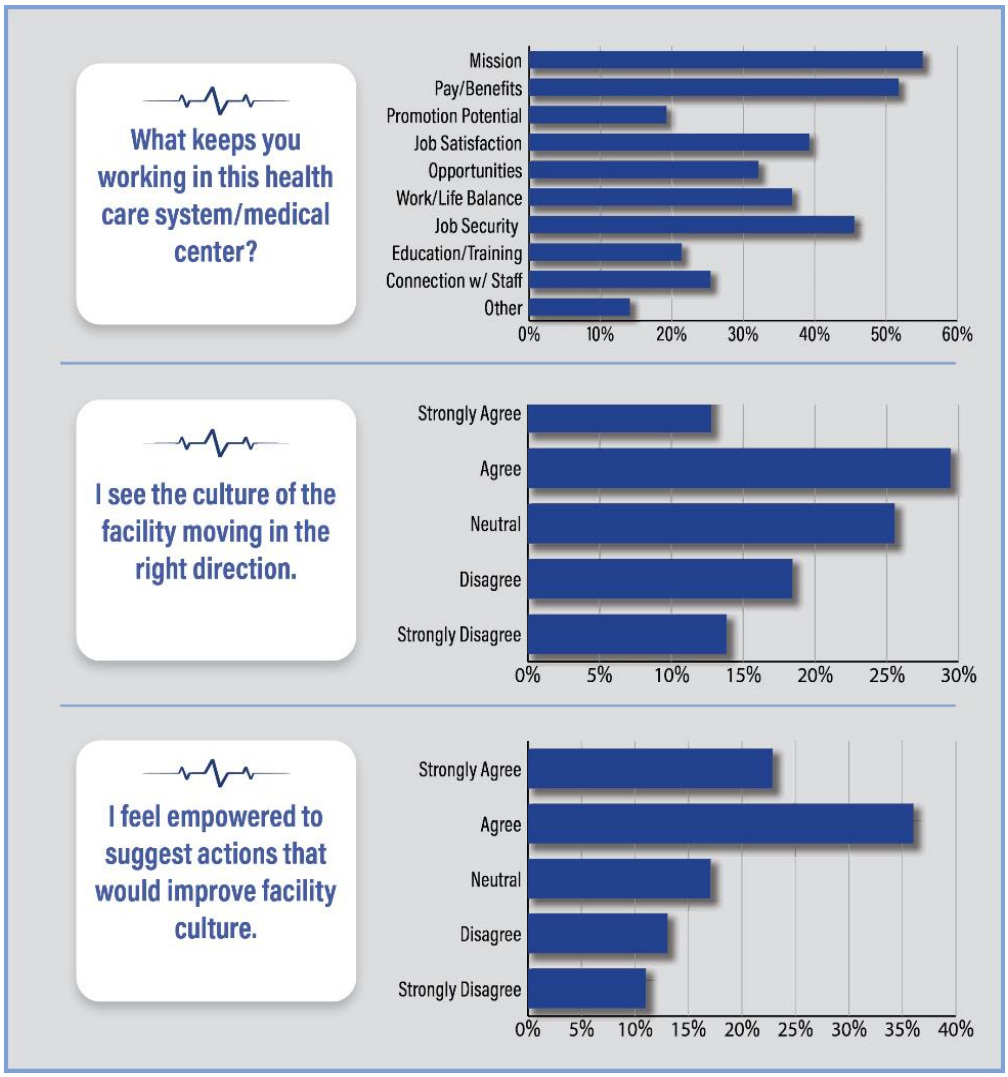


Figure 7. *Employee perceptions of facility culture.*
Source: Analysis of OIG-administered survey responses.

[29] 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.

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

The OIG reviewed survey questions and leaders' interview responses related to psychological safety. The OIG found the All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety also increased from FYs 2022 to 2023.

The executive leaders attributed the improvement to investing in the employee experience, ensuring front-line leaders have the resources they need, working to make both veterans and employees feel happy and cared for at the facility, and closing the loop by providing an answer or follow-up when employees ask questions. In the OIG-administered staff survey, respondents largely indicated that the VA mission kept them at the facility, and they felt empowered to make suggestions to improve the culture. Staff were split on whether the culture of the facility was moving in the right direction. The survey responses also showed staff commonly identified stress and burnout as reasons they might leave the facility. The executive leaders also told the OIG they recently hired a Chief Clinical Wellbeing Officer to focus on provider burnout and offered several employee programs to improve the overall culture, including the Whole Health Program and Wellness Rooms.[31]

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.[32] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[33] The OIG reviewed patient advocate reports and VSO surveys to understand veterans' experiences with the facility.

In an OIG-administered questionnaire, the Patient Advocate noted the three most common complaints from patients were disagreements about treatment plans, uncoordinated care, and delayed communication by providers and staff. The Patient Advocate also noted that executive leaders were responsive to veterans' concerns and effectively addressed the veterans' most common complaints.

The executive leaders stated they meet regularly with VSOs and other veteran advocacy groups to share information. Three of 21 VSOs responded to an OIG survey asking for feedback about working with the facility and the PACT Act's implementation. VSO staff reported they could

[31] "Whole Health is VA's approach to care that supports your health and well-being. Whole Health centers around what matters to you, not what is the matter with you." "Whole Health," Department of Veterans Affairs, accessed March 25, 2024, https://www.va.gov/wholehealth/. The facility "provides a variety of wellness activities, such as affirmations, shaking and dancing, coloring, tea-time, massage, aromatherapy and meditation." "VA News, Employee Wellness Provides Around-the-Clock Whole Health Services," Department of Veterans Affairs, accessed March 25, 2024, https://news.va.gov/wellness-whole-health-services/.

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

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

provide feedback to facility leaders about care provided to veterans and the leaders were responsive to their and the veterans' concerns.

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.[34] The OIG examined the general entry touchpoints, which are features that assist veterans in accessing the facility and finding their way around. To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints, 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 8. *VA Orlando Healthcare System. Source: https://www.va.gov/orlando-health-care/ (accessed April 4, 2024).*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[35] 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, Architectural Barriers Act guidelines, 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.[36]

[34] VHA Directive 1608(1).

[35] 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.

[36] 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.

Transit and Parking

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

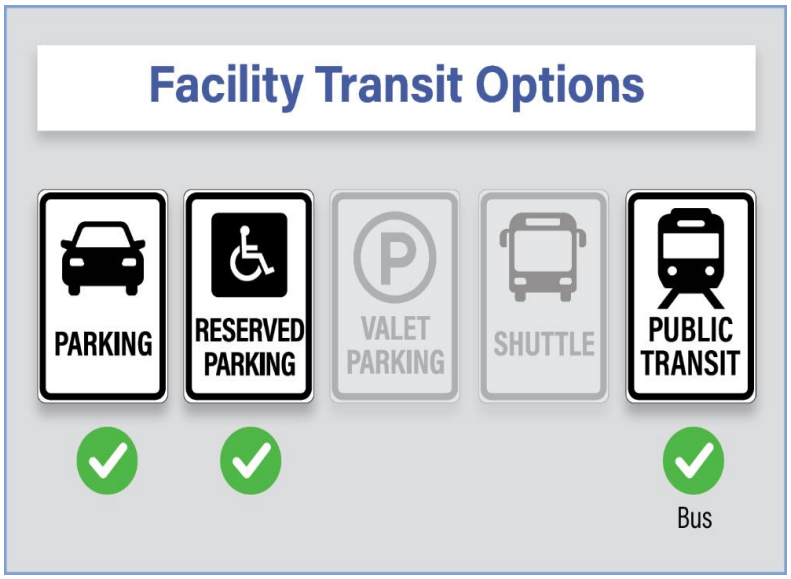


Figure 9. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG used the navigation link located on the facility's public website to obtain directions to the facility. The link guided the OIG team to the facility's main entrance. The OIG determined the facility had ample parking, including accessible spaces with some reserved for those with spinal cord injuries. The parking garage was well-lit and used colored lights to show whether the parking space was physically taken (red) or available (green). The OIG noted four public transit bus stops located approximately 0.3 miles from the facility's main gate, and the public buses stopped there hourly.

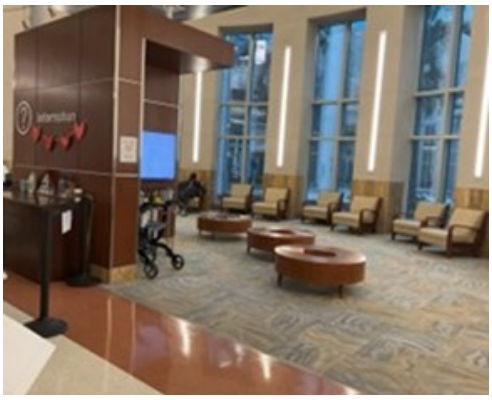


Figure 10. *Main entrance information desk.*
Source: Photo taken by OIG inspector.

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.[37]

The OIG noted the main entrance to the facility was well-marked by signage in the driveway, in the parking garage, and on the building. The OIG found the exterior of the main entrance to be welcoming, with a soothing water feature, a garden, and ample seating areas. The OIG noticed a passenger loading zone with a canopy to shelter patients and visitors. The main entrance was accessible by steps and wheelchair ramps.

The OIG team entered the facility through power-assisted doors. Once inside, the OIG found a well-kept entrance area with a volunteer-staffed information desk and assistive devices such as

[37] 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*.

wheelchairs. Just beyond the main information desk, the OIG noted a seating area, as well as an area to purchase drinks and snacks. Although construction was ongoing at the front of the facility, visitors could converse at normal levels. The facility communicated information through wall signs and large television screens that rotated through information.

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.[38]

The OIG noted that volunteers and employees staffed the facility's multiple information desks and provided printed maps of the facility. In addition, wall signs, large television screens, and a mobile application assisted patients and visitors in navigating the facility. The OIG tested the mobile application, which provided individualized directions, and followed wall signage to successfully navigate through the facility.

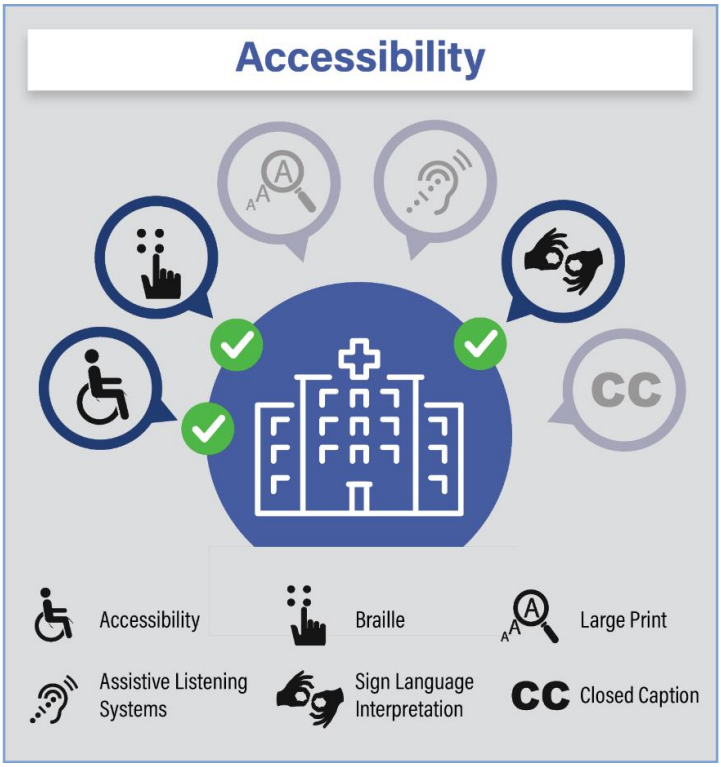


Figure 11. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[39] The OIG found no complaints to the Patient Advocate's office about accessibility problems among veterans with sensory impairments. During a walk-through inspection, the OIG confirmed the availability of braille on signage and kiosks located throughout the facility.

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

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

Toxic Exposure Screening Navigators

VA required each facility to 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 guidelines.[40]

At the time of the OIG site visit, facility staff reported completing initial toxic exposure screenings for about 103,000 veterans, with approximately 47,000 veterans reporting a toxic exposure. The facility had three toxic exposure screening navigators. The OIG team interviewed the lead navigator, who described the facility's screening processes and resources: staff completed initial screenings at outreach events and nursing staff screened veterans during primary or specialty care appointments or emergency department visits. If a veteran indicated they had been exposed to toxins, a provider performed a secondary screening. If providers did not complete this screening during a scheduled appointment, the navigators entered a clinical reminder into the veteran's electronic health record that would alert the provider the secondary screening was due. Staff reported understanding that providers must complete clinical reminder tasks within 30 days. At the time of the OIG site visit, the facility had zero overdue clinical reminder tasks.

Facility staff said they conducted six toxic exposure screening outreach events. Additionally, the OIG noted flyers available in multiple languages located at the facility's information desks. The lead toxic exposure screening navigator reported no access, space, or wait-time barriers to screenings. The lead further stated the electronic health record system was not capturing the toxic exposure screening in a veteran's problem list, and as a result, providers were unable to ascertain whether the veteran had completed the screening process. In response, facility staff were reviewing electronic health records for over 30,000 veterans to ensure each problem list was updated to capture the screening. Additionally, leaders trained all providers on how to link the toxic exposure screening documentation to the electronic health record, so the screening information was included in the veteran's problem list.

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.[41]

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

[40] 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.

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

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

The OIG found that in FY 2023, facility staff did not meet VHA's Comprehensive Environment of Care Committee performance measure target for closing identified environment of care deficiencies or creating an action plan to address them within 14 business days. VHA set the performance measure target at 90.0 percent, and the facility's compliance rate was 88.8 percent. However, facility leaders met the performance measure target for attending environment of care rounds.[42] In an interview, the comprehensive environment of care round leaders explained that staff spoke with stakeholders to identify problematic areas and determine why they had repeated deficiencies prior to implementing action plans. The OIG did not make a recommendation to improve the compliance rate due to the facility's overall acceptable condition and staff's responsiveness to the few deficiencies found during the OIG's inspection.

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 inspected four clinical areas and found them all to be clean, well-lit, and free of clutter.[43] The OIG noted there were clear paths for egress and patients were able to move freely. In addition, the OIG found the medical equipment all had current inspection stickers and no protected patient information visible. However, the OIG found expired medications and a power cord missing an outer covering. Facility staff addressed these issues immediately.

The OIG also inspected the locked dementia unit (Spring Hill) in the community living center. A covered walkway led to the community living center, which consisted of several units that shared the main entrance. The OIG found the main entrance to be open and inviting, with ample seating, a large television, and an aviary (bird cage). The OIG considered the Spring Hill unit to be warm and homelike, noting that each resident had their own room. The dining room was large and open with a television, fireplace, and windows, where the residents could view the Veteran Memorial and a river. Although the kitchen area was locked, except during mealtimes, the unit had snacks, juices, and milk readily available. The OIG observed some issues on the Spring Hill unit, including a stained hallway tile, a hole in the drywall, an expired water filter on a faucet, a cleaning cart in the soiled utility room, and residents' access to a towel warmer with a fire hazard

[42] Acting Deputy Assistant Under Secretary for Health for Operations, "Fiscal Year (FY) 2023 Comprehensive Environment of Care (CEOC) Guidance (VIEWS 9547420)," memorandum to Veterans Integrated Service (VISN) Directors, February 21, 2023.

[43] The OIG inspected the emergency department, intensive care unit, 4B medical/surgical unit, and Hero primary care clinic.

label on it. Facility staff addressed these issues immediately. The OIG also found that the pneumatic tube system used to transport medications from the pharmacy to the dementia unit was unsecured, which could allow unauthorized persons or residents to access the medications. The OIG recommended that staff secure the pneumatic tube system to prevent unauthorized access.

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.[44] 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.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG determined the facility had processes to communicate abnormal test results to ordering providers, to identify a surrogate provider when an ordering provider was unavailable or had left the facility, and to communicate results outside regular clinic hours. The OIG also found staff performed quarterly internal audits that included a review of the External Peer Review Program communication of test results data.[46] In an interview, the Chief of Staff and quality management staff reported that the internal audit did not identify any major delays in provider notification of test results.

Electronic health record alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings."[47] When alert

[44] VHA Directive 1088, *Communicating Test Results to Providers and Patients*, July 11, 2023.

[45] 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.

[46] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance and ensure "corrective actions are taken when non-compliance is identified." VHA Directive 1088.

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

fatigue occurs, providers may fail to notify patients of urgent noncritical test results, which in turn may put the patient's health at risk. The OIG found that service chiefs addressed alert fatigue by regularly reviewing alert data, maintaining a mandatory view alert list, and training providers to set up and manage alerts within the electronic health record system.

Action Plan Implementation and Sustainability

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[48] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

Figure 12. *Status of prior OIG recommendations to facility.*
Source: OIG analysis of documents.

The OIG reviewed reports, surveys, and reviews involving the facility for the past three years and did not find any open recommendations. Through a panel interview with the Chief of Staff and quality management staff, the OIG learned the facility's process involved staff from different departments collaborating to ensure employees sustained the action items, and quality management staff monitored sustainment and reported results to executive leaders. The OIG did not identify any barriers to long-term improvements related to general patient safety.

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.[49] 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.[50] 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 Chief of Staff and quality management staff reported that facility leaders supported process improvement projects and there were no barriers for staff initiating such projects. For example, the Chief of Pathology shared a new process improvement project that staff initiated within pathology to reduce errors. Previously, pathology staff had disorganized workspaces and lacked a case file sorting methodology; they mixed new, pending, and finished case files together,

[48] VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.
[49] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.
[50] VHA Directive 1050.01(1).

which led to errors. The initiative involved staff using color-coded bins to organize files and standardizing work processes. Leaders planned to audit the new process to ensure improvement and sustainment of change.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[51] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[52] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[53] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

At the time of the OIG site visit, the facility did not have any primary care provider staffing shortages. Although the Primary Care Service had a shortage of registered nurses, licensed practical nurses, and administrative associates, the OIG found patients did not experience increased appointment wait times or delays in care. In an interview, facility leaders said they expedited hiring and prioritized recruiting and stated that clinics in some locations, such as Daytona Beach, had significant challenges with recruitment and retention due to being in a less desirable area in Florida. In addition, the facility competed with local hospitals for the same qualified nursing candidates. Leaders, together with human resources staff, reported aggressively recruiting for hard-to-fill positions by creating partnerships with local community colleges, hosting job fairs open to applicants from all counties, and increasing pay incentives and extending student loan repayment to nurses. The leaders stated the staffing shortages did not negatively affect patient care because they reallocated staff to the primary care clinics experiencing shortages.

[51] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended May 26, 2017, and February 29, 2024.

[52] 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).

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

To prepare for increased patient enrollment due to the PACT Act, facility leaders created eight new primary care teams and established interim care clinics in every location.[54] Leaders reported that patient appointment wait times decreased from a high of 32 days for the clinic in Daytona Beach to less than 20 days across the facility.

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.[55] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[56]

The OIG found panel sizes were generally a concern for leaders and primary care teams. According to facility leaders, VHA sets panel sizes nationally, and the size does not account for patients' complex medical or psychiatric conditions. Although concerned about panel sizes, primary care team members said that using interim care clinics for walk-in patients alleviated some of the burdens of large panel sizes and provided a more even workload distribution.

Leadership Support

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

In interviews, primary care team members said they found facility leaders supportive, and leaders worked with them to improve efficiency and team functioning. Facility leaders reported supporting staff's creativity and encouraging them to present on best practices and performance improvement projects at meetings.

Staff provided the OIG examples of several performance improvement projects being piloted at the facility to increase primary care efficiency. For example, staff formed a multidisciplinary partnership with inpatient, emergency department, nurse navigator, and enrollment staff to create a process to establish follow-up care for veterans who had not been assigned to a primary care team and received treatment in the emergency department. This initiative allowed staff to follow-up with 847 unassigned veterans and enroll 79 percent of them into primary care teams. This

[54] According to facility leaders, the interim care clinics provide services to unassigned and traveling veterans, and patients who need to be seen for routine care.

[55] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. As of April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[56] Team modeled capacity is the maximum number of patients the facility's primary care teams are expected to care for considering various factors such as staffing. Active panel size is total number of patients currently assigned to the facility's primary care teams. Percent of adjusted panel assigned is the percentage of the facility's actual panel sizes as compared to the modeled capacity. VHA Directive 1406(1).

[57] VHA Handbook 1101.10(2).

initiative was recognized nationally as a best practice and chosen to be presented at the first national care coordination and integrated case management conference in October 2023.

The PACT Act and Primary Care

The OIG reviewed the facility's increase in veteran enrollment following PACT Act implementation and determined whether the increase had an impact on primary care delivery. The OIG found the increase in veteran enrollment rates from FYs 2021 through 2023 did not affect wait times for new or established primary care patients. In response to the PACT Act implementation, facility leaders reported initially increasing staff to meet the projected demand. However, while reviewing demographic data and trends, facility leaders learned veterans were moving out of Florida faster than they were moving in. As a result, the facility's enrollment rate has remained stable. Primary care team members reported that adding toxic exposure screenings did not affect how the team functioned or the timeliness of care.

The OIG reviewed 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.[58]

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).[59] VA uses the Department of

All homeless program staff have outreach services included in their job duties and responsibilities to maximize identification and enrollment of unsheltered veterans into the homeless programs.

Figure 13. *A best practice for veteran engagement.*
Source: OIG analysis of documents and interviews.

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

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

Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[60]

The facility's HCHV program did not meet VHA's performance measure target for the engagement of unsheltered veterans in FYs 2022 or 2023.[61] HCHV staff explained the metric included only veterans who are eligible for health care. Because the metric excludes veterans who are ineligible, HCHV staff found it failed to account for all veterans who used HCHV services.[62] HCHV staff further reported the point-in-time count accurately captured the number of sheltered and unsheltered homeless individuals on a specific night but was perhaps less accurate in identifying the total number of unsheltered veterans. After learning about underserved veterans accessing services through faith-based programs, HCHV staff told the OIG they recently expanded outreach locally to those programs to help connect the veterans to VA resources.

Meeting Veteran Needs

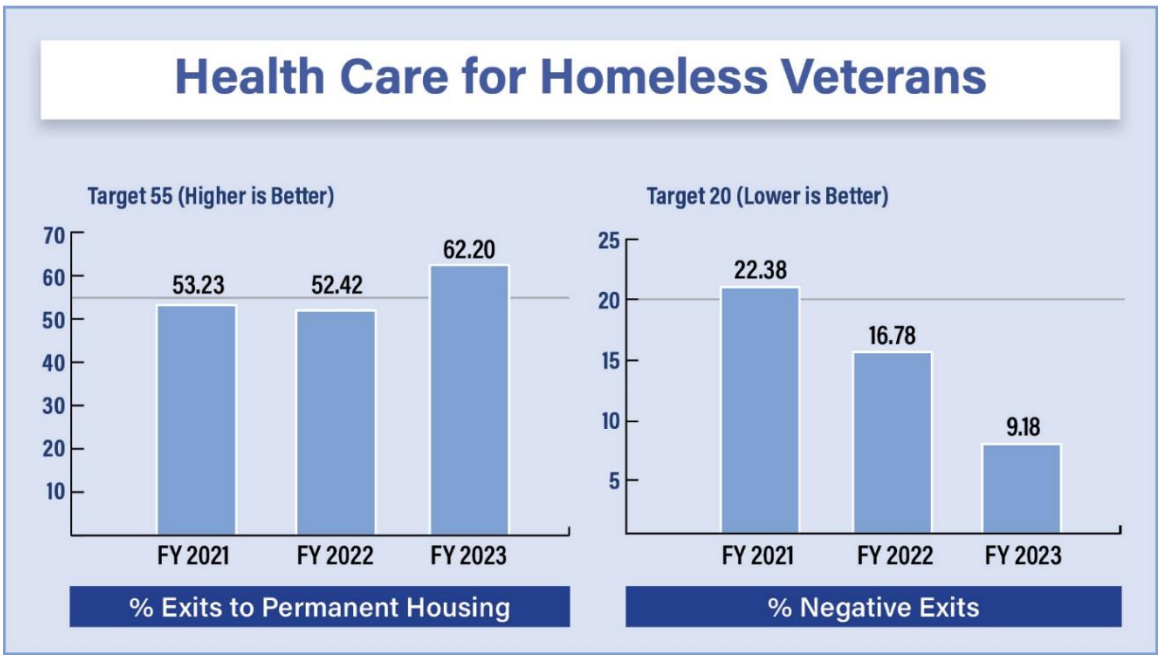


Figure 14. *National metrics for HCHV program.*
Source: OIG analysis of VHA homeless performance measures data.

[60] 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.

[61] VHA sets escalating targets for HCHV5 at the facility level each year with the goal to reach 100 percent by the end of the FY. The facility's HCHV5 measure reached 55.74 percent for FY 2022 and 55.19 percent for FY 2023. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

[62] Not all veterans who used HCHV services are eligible or enrolled in VA healthcare services. VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[63]

The OIG noted the facility met performance measure targets for HCHV1 and HCHV2 for FY 2023. In an interview, HCHV staff explained these measures demonstrated their success in rapidly engaging with unsheltered veterans and connecting them to resources and showed the program's support for the national goal of providing housing as an initial service. Further, HCHV staff highlighted a trend from the national homeless hotline: previously, most calls came from unsheltered veterans seeking housing but now most were from veterans at risk of homelessness seeking assistance to remain housed. HCHV staff said this shift to requests for prevention services indicated the program had made a positive impact.

According to HCHV staff, the outreach process includes identifying unsheltered veterans through relationships with community partners and referrals from individuals. Once identified, staff engage with the veteran, assess their needs, and track the needs to resolution. To increase housing options within the facility's service area, staff described fostering relationships with owners and landlords. However, they reported two major barriers veterans face: transportation and affordable housing. For example, limited transportation became a challenge after the expiration of the COVID-19 public health emergency's rideshare options for unscheduled healthcare appointments.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[64] 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.[65]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[66] The facility met the performance measure goal for FY 2023. The

[63] VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 target (negative exits) was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

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

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

[66] 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. For FY 2023, the facility's target was 252 veterans entering the Veterans Justice Program. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

OIG noted the program team consisted of six outreach specialists who served veterans at treatment courts and jails within six counties. The specialists conducted over 60 outreach and educational events from FYs 2020 through 2023. In an interview, the Homeless Program Supervisor stated that VISN 8 staff performed state and federal prison outreach. The supervisor added that staff work with internal partners, including mental health staff, and external partners such as local law enforcement, court staff, VSOs, and community organizations to assist veterans participating in the program.

Meeting Veteran Needs

In an interview with the Homeless Program Supervisor, the OIG learned that program staff assess veterans' psychosocial needs and refer them for medical and mental health services as necessary. The supervisor added that lack of timely access to outpatient mental health and substance use treatment could delay some veterans' participation in the veterans treatment court and release from custody.[67] The Homeless Program Supervisor reported being unaware of any facility-wide plans to address the potential delay in access to mental health care.

A male veteran was arrested for domestic violence. The court offered to dismiss charges if the veteran participated in the Strength at Home program. Although initially resistant, the veteran completed the Strength at Home program, graduated from veterans treatment court, and became successful working as a veteran's service officer. Strength at Home is a trauma-informed, evidence-based therapy program for those who use aggression in romantic relationships. The program focuses on cognitive behavioral therapy and anger management and helps people understand their underlying issues, see how their interactions are affecting others, and how trauma affects their reactions.

Figure 15. *A best practice for the Veterans Justice Program. Source: OIG interview.*

Housing and Urban Development-Veterans Affairs Supportive Housing

Housing and Urban Development-Veterans Affairs Supportive Housing combines Department of Housing and Urban Development rental vouchers and VA case management services for veterans requiring the most aid to remain in stable housing, including those "with serious mental illness, physical health diagnoses, and substance use disorders."[68] 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.[69]

[67] 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(1), *Veterans Justice Programs (VJP)*, September 27, 2017, amended March 3, 2020. VHA rescinded and replaced this directive with VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

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

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

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).[70]

The OIG found the program did not meet the HMLS3 performance measure target for FYs 2022 or 2023. In an interview, the Homeless Program Coordinator explained the program's outreach efforts focused on identifying and enrolling veterans who need housing and case management services. Although program staff reported rapidly identifying and enrolling veterans through their outreach efforts, the coordinator stated they did not meet the performance measure target because the supply of vouchers exceeded the number of eligible veterans who accepted case management services, and there was a lack of affordable housing options throughout the service area.

Meeting Veterans Needs

VHA measures how well the Housing and Urban Development-Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[71]

The OIG found the facility's Housing and Urban Development-Veterans Affairs Supportive Housing program met the VASH3 target for FYs 2022 and 2023. In an interview, the Homeless Program Coordinator highlighted the work of the program's employment coordinator as a contributing factor in achieving the target. By maintaining regular contact with case managers, the employment coordinator helped ensure the program's database accurately reflected veteran employment status. In addition, the employment coordinator assisted veterans with resume writing, identified veteran-friendly employers, and matched enrolled veterans with minority- and women-owned businesses.

The Homeless Program Coordinator also described how staff use an assessment tool to determine veterans' needs and acuity status, accounting for medical conditions, mental health, substance use, and income, then track veterans until

A veteran was in stable housing for three and a half years, but the property was sold and the new owners no longer accepted the housing voucher. The veteran had a large family, and it was difficult to find affordable and spacious housing. Through the work of multiple case managers and incentive funding from community programs, a veteran homeowner agreed to rent a home to the veteran.

Figure 16. *A best practice for outreach and veteran engagement. Source: OIG interview.*

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

[71] 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*.

their needs are met. Staff update the tool's information regularly, and the updates trigger the frequency of staff visits with veterans and guide the treatment plans and services provided.

The Homeless Program Coordinator further discussed working with various internal and external community partners. The facility's voluntary service staff often supplied housewares and food for program participants. Local public housing authorities provided subsidized housing, and community programs assisted with security deposits, application fees, and incentives to landlords who accepted program participants. However, even with this support, the coordinator identified two barriers in meeting veterans' needs: transportation and affordable housing. The coordinator said the public bus system was inefficient across six counties and rideshare benefits for unscheduled appointments were no longer available. The coordinator also stated affordable housing was limited in accessible locations, which results in veterans moving to more remote and isolated areas. In response, staff were working with veterans and housing authorities to consider alternative options, including shared housing and extended stay hotels.

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.

Summary of Findings and Recommendations

The OIG stratified inspection findings using a scoring matrix, based on the severity, frequency, and facility leaders' awareness of the events, and OIG leaders approved the findings based on content and professional judgment.

- Critical: An actual or potential deficiency in process, practice, or system management that negatively affects the health and safety of veterans, VA and VHA employees, or the public to a catastrophic degree; represents a violation of applicable rules or guidelines; and facility leaders are either unaware or not actively addressing. Any death of a veteran, VA and VHA employee, or member of the public is considered a critical finding.
- Major: An actual or potential deficiency in process, practice, or system management that leads to a negative impact on the health and safety of veterans, VA and VHA employees, or the public; represents a violation of applicable rules or guidelines; and facility leaders may or may not be aware.
- Minor: An actual or potential deficiency in process, practice, or system management that potentially leads to a negative impact on the health and safety of veterans, VA and VHA employees, or the public; represents a violation of applicable rules or guidelines; and facility leaders are aware and addressing.

Minor

Finding: Facility leaders increased bed levels on three inpatient units to accommodate demand during the COVID-19 pandemic. Since the end of the pandemic, staff have decreased the bed levels to the approved amount on one unit. However, the other two units' bed levels remain above capacity.

Recommendation 1: The OIG recommended the Facility Director work with Veterans Integrated Service Network leaders to reevaluate the current bed level capacity and submit the bed change request as required.

Finding: The dementia unit's pneumatic tube system for medication deliveries was unsecured.

Recommendation 2: The OIG recommended the Facility Director ensures staff secure the pneumatic tube system to prevent unauthorized access to medications.

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, relevant prior OIG reports, and accreditation survey reports.[1] The OIG submitted questions for review and response by facility staff prior to inspection and created a survey for distribution to 21 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 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 survey 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 inspected the facility from February 12 through February 16, 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 received responses from three VSOs: Sons of the American Revolution, Soldiers' Angels, and Vietnam and all Veterans of Central Florida.

[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
Race and Ethnicity	Race and Ethnicity	Census population by race/ethnicity are from the Census Redistricting Data (Public Law 94-171) Summary File, US Census Bureau.
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	Veteran population estimates are from the Department of Veterans Affairs' Veteran Population Projection Model 2018.
	Homeless Population	Point-in-time (PIT) estimates offer a snapshot of homelessness—both sheltered and unsheltered—on a single night.
	Veteran Homeless Population	Point-in-time (PIT) estimates offer 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 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 with high school diploma or more and with four years of college or more 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 persons to the civilian labor force.

Category	Metric	Metric Definition
	Veteran Unemployed in Civilian Workforce	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.
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 on this report were coded according to International Classification 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).
Transportation	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.
Access to Health Care	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.

Category	Metric	Metric Definition
	Average Drive to Closest VA	The distance and time between the patient residence to the closest VA site.

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.

Category	Metric	Metric Definition
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 unique employee fills the position.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.
	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 figures 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: August 14, 2024

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Facility Inspection of the VA Orlando Healthcare System in Florida

To: Director, Office of Healthcare Inspections (54HF02)

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

I have reviewed the OIG's report and the Orlando VA Healthcare System Director's response and concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

David Isaacks, FACHE
VISN 8 Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 6, 2024

From: Director, VA Orlando Healthcare System (675)

Subj: Healthcare Facility Inspection of the VA Orlando Healthcare System in Florida

To: Director, VA Sunshine Health Network (10N8)

I have reviewed the VAOIG's Healthcare Facility Inspection of the Orlando VA Healthcare System and concur with the findings and recommendations. I have included our actions addressing all findings.

(Original signed by:)

Timothy J. Cooke
Medical Center Director/CEO

Appendix E: VA Responses

Recommendation 1

The OIG recommended the Facility Director work with Veterans Integrated Service Network leaders to reevaluate the current bed level capacity and submit the bed change request as required.

___X__Concur
_____Nonconcur

Target date for completion: September 13, 2024

Director Comments

The Orlando VA Healthcare System has been reassessing the current bed capacity since the impact of the pandemic. Executive Leadership directed an evaluation by the Patient Flow Committee to analyze current bed utilization trends including seasonal variations. The Patient Flow Committee held meetings during July and early August 2024 and submitted a recommendation to ELT on August 5, 2024. Orlando VA Healthcare System will coordinate with Veterans Integrated Service Network (VISN) and submit a new bed letter by September 13, 2024.

Recommendation 2

The OIG recommended the Facility Director ensures staff secure the pneumatic tube system to prevent unauthorized access to medications.

___X__Concur
_____Nonconcur

Target date for completion: Completed

Director Comments

The Orlando VA Healthcare System Facility Director evaluated and determined there were no additional reasons for noncompliance. The pneumatic tube system door was closed and secured while the inspector was onsite. The Chief Nurse of Geriatrics and Extended Care and Nurse Manager educated staff on properly securing the pneumatic tube system. Daily spot checks to ensure a secured pneumatic tube system were conducted with 100% compliance. Random spot checks will continue to ensure compliance.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

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