



US DEPARTMENT OF VETERANS AFFAIRS **OFFICE OF INSPECTOR GENERAL**

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the West Palm Beach VA Healthcare System in Florida

**Healthcare Facility
Inspection**

25-00190-226

September 23, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the West Palm Beach VA Healthcare System (facility) from January 14 through 16, 2025.¹ The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. The OIG found that executive leaders effectively managed a system shock and minimized disruptions to facility operations during a severe weather event.

After a tornado and hurricane in October 2024, executive leaders learned that some staff had not responded to the emergency communication system's prompt to indicate they were unharmed. Leaders called staff who did not reply to ensure they were safe and had them update their information in the system.

Executive leaders share information through town halls and during visits to staff in their work areas. They also film short videos to highlight employees' positive effect on veterans' healthcare through social media posts. However, executive leaders identified a need to increase leadership skills among frontline supervisors and responded by providing them with additional training opportunities.

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.

A patient advocate reported that leaders and staff quickly resolve veterans' concerns. For example, in response to complaints regarding the phone system, leaders implemented a VA Health Chat mobile application that veterans can use to schedule appointments, inquire about health concerns, and request prescription medications.²

Environment of Care

The OIG examined the general entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also physically inspected patient care areas and compared findings from prior inspections to determine if there were recurring issues.

The OIG found the facility easy to navigate and had available parking. The entrance was welcoming and had wheelchairs available as well as volunteers to assist veterans as needed. During the physical inspection, the OIG found the facility was generally clean. However, the community living center had a ceiling leak. Because staff shared plans to resolve the issue, the OIG did not issue a recommendation.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found that facility staff had established processes to manage the communication of test results.³

There were no open recommendations from previously published OIG reports.⁴ Leaders and staff identified opportunities for improvement by reviewing quality of care data, such as electronic health records, and patient safety events.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson

² "VA Health Chat," Department of Veterans Affairs, accessed January 21, 2025, <https://mobile.va.gov/health-chat>.

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

⁴ VA OIG, [Comprehensive Healthcare Inspection of the West Palm Beach VA Medical Center in Florida](#), Report No. 21-00272-283, September 29, 2021; VA OIG, [Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida](#), Report No. 22-01594-86, March 30, 2023.

Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.⁵

The OIG learned there were 19 primary care position vacancies for registered nurses, licensed practical nurses, and medical support assistants, and 6 for primary care physicians. The Chief of Primary Care discussed challenges hiring physicians due to the area's high cost of living and the competitive private sector salaries. To address these challenges, leaders used national recruiter services, hired candidates from medical schools, and offered the education debt reduction program to reduce student loan costs.⁶ Staff also reported it was difficult to hire medical support assistants because of low pay and held an open house to increase applicants.

The Patient Centered Management Module Coordinator and primary care leaders held weekly meetings to review primary care team panels (patients assigned to a team) to maintain manageable sizes.⁷ Primary care staff informed the OIG that manageable panel sizes allowed them to take appropriate care of their patients. The OIG found that primary care leaders' actions—regularly checking panel sizes and supplementing staffing with float providers—ensured patients had timely access to care.⁸ Primary care staff also told the OIG that facility leaders were responsive to their concerns.

The OIG found that patient enrollment had declined slightly from fiscal years (FYs) 2022 through 2024. Executive leaders said patients relocated north of West Palm Beach, so they were taking steps to open a multispecialty clinic in June 2025 and an outpatient clinic in 2028 to serve veterans in that area. Primary care staff stated the PACT Act did not affect the teams' efficiency.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development—Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans program did not meet the performance target for veterans who received an intake assessment in FYs 2022 and 2024, which program leaders attributed to staffing issues and limited outreach in those years. The section chief reported hiring staff to fill

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

⁶ VHA Handbook 1021.01, *Education Debt Reduction Program Procedures*, May 31, 2012.

⁷ The Patient Centered Management Module Coordinator manages staff and patient assignments for all primary care locations, and identifies the maximum panel capacity for the facility primary care teams. The maximum capacity is “the total number of patients that should be assigned to a team based on its station, care type, intensity score and rooms available at the station.” VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025

⁸ Float providers provide coverage for planned or unplanned primary care provider absences. VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

vacant positions, and the assistant chief discussed developing a dashboard to monitor performance measures.

The Health Care for Homeless Veterans program also missed the performance goal for veterans discharged from transitional to permanent housing in FY 2022 but exceeded targets in FYs 2023 and 2024. From FYs 2022 through 2024, the program also beat targets for discharging veterans from the program without permanent housing, which leaders attributed to collaborative relationships with contract emergency residential services staff. For example, VA staff trained contract emergency residential services staff to assist veterans with mental health disorders instead of discharging them from the program.⁹

The Housing and Urban Development–Veterans Affairs Supportive Housing program did not meet the target for the percentage of housing vouchers assigned in FYs 2022 through 2024. Program leaders cited high rental costs, lack of affordable housing, and multiple staffing vacancies as reasons why the facility did not meet the target. Program staff reported hiring additional staff, including a housing specialist, to build relationships with landlords interested in renting to veterans.

However, the Veterans Justice Program exceeded targets for veteran enrollment in FYs 2023 and 2024. Program staff said their success was because they worked together as a team, conducted effective outreach, collaborated with lawyers in the community to provide free legal services to veterans at the facility, and encouraged first responders to send veterans to treatment for mental health and substance use disorders in lieu of incarceration.

What the OIG Recommended

Based on this inspection of the five content domains, the OIG has no recommendations.

⁹ In addition to outreach services, HCHV programs include transitional housing and case management services through contracts with community providers. “Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing.” VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the report (see appendixes C and D). No further action is required.



JULIE KROVIK, MD

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

Abbreviations

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

FACILITY IN CONTEXT

Description of Community

MEDIAN INCOME

\$66,051

EDUCATION

89% Completed High School
63% Some College

POPULATION

Female
2,035,595

Veteran Female
17,865

Male
1,929,384

Veteran Male
182,283

Homeless - State
25,959

Homeless Veteran - State
2,279

VIOLENT CRIME

Reported Offenses per 100,000

348

SUBSTANCE USE

21.0% Driving Deaths Involving Alcohol

21.6% Excessive Drinking

1,321 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+

4% Veterans Unemployed in Civilian Workforce

AVERAGE DRIVE TO CLOSEST VA

Primary Care **11.5 Minutes, 7.5 Miles**

Specialty Care **34.5 Minutes, 30.5 Miles**

Tertiary Care **81 Minutes, 84 Miles**

TRANSPORTATION

Drive Alone **1,420,222**

Carpool **172,490**

Work at Home **134,449**

Other Means **43,100**

Public Transportation **34,352**

Walk to Work **22,807**

ACCESS

VA Medical Center
Telehealth Patients **14,265**

Veterans Receiving Telehealth (VHA) **41%**

Veterans Receiving Telehealth (Facility) **28%**

<65 without Health Insurance **21%**

Access to Health Care

Health of the Veteran Population

278

VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

12,856



AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

4.97 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

Suicide Rate (state level)

19

Veteran Suicide Rate (state level)

37

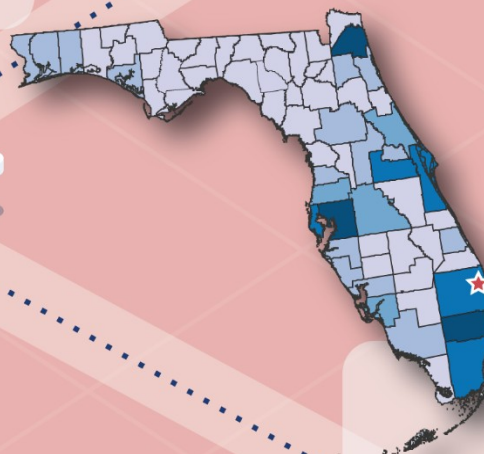
UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	56K
Unique Patients VA Care	54K
Unique Patients Non-VA Care	20K



STAFF RETENTION

Onboard Employees Stay <1 Yr	9.76%
Facility Total Loss Rate	12.23%
Facility Retire Rate	2.78%
Facility Quit Rate	8.52%
Facility Termination Rate	0.68%



COMMUNITY CARE COSTS

Unique Patient \$10,696	Outpatient Visit \$256
Line Item \$323	Bed Day of Care \$301

★ VA MEDICAL CENTER
VETERAN POPULATION

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

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Background and Vision

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

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

Healthcare Facility Inspection reports illuminate each facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. These reports are intended to provide insight into the experience of working and receiving care at VHA facilities; inform veterans, the public, and Congress about the quality of care received; and increase engagement for facility leaders and staff by noting specific actions they can take to improve patient safety and care.

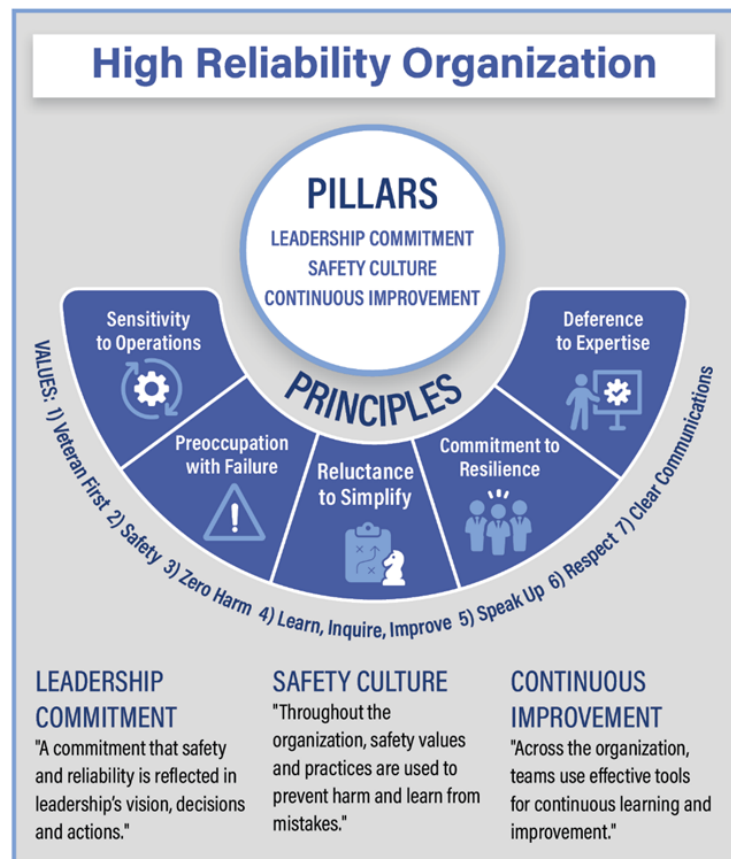


Figure 1. VHA's high reliability organization framework.

Source: Department of Veterans Affairs, "VHA's Journey to High Reliability."

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

High Reliability Organization Framework

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

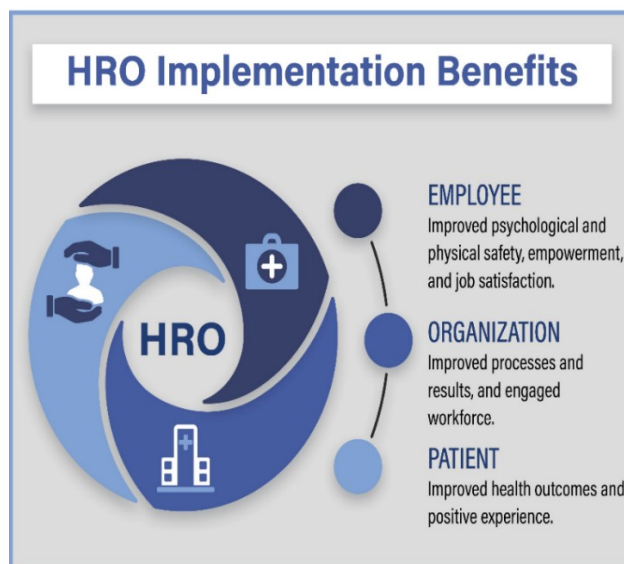


Figure 2. Potential benefits of HRO implementation.
Source: Department of Veterans Affairs, “VHA High Reliability Organization (HRO), 6 Essential Questions,” April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.⁷ Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.⁸ The OIG inspectors observed how facility leaders incorporated high reliability principles into their operations.

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

³ Veazie, Peterson, and Bourne, “Evidence Brief: Implementation of High Reliability Organization Principles.”

⁴ “PSNet Patient Safety Network, High Reliability,” Agency for Healthcare Research and Quality, September 7, 2019, <https://psnet.ahrq.gov/primer/high-reliability>.

⁵ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

⁶ “VHA Journey to High Reliability, Frequently Asked Questions,” Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourny/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

⁷ “PSNet Patient Safety Network, High Reliability,” Agency for Healthcare Research and Quality.

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

PACT Act

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

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

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

¹¹ Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), “Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844),” memorandum to Under Secretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), “Toxic Exposure Screening Installation and Identification of Facility Navigators,” memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, “PACT Act Claims Assistance,” memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

¹² “VA PACT Act Performance Dashboard,” VA. On May 1, 2023, VA’s website contained this information (it has since been removed from their website).

Content Domains



Figure 3. Healthcare Facility Inspection's five content domains.

*Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," *BMJ Open* 7, no. 11 (2017): 1–11.

Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," *Harvard Business Review* 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), *Patient Centered Management Module (PCMM) for Primary Care*, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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

The West Palm Beach VA Healthcare System (facility) opened in 1995. In fiscal year (FY) 2023, the facility's medical care budget was approximately \$845 million, and it had 333 operating beds (153 hospital, 120 community living center, and 60 domiciliary beds).¹³

The OIG inspected the facility from January 14 through 16, 2025. The executive leaders consisted of the Executive Director (Director), Deputy Executive Director, Associate Director of Operations, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Assistant Director. The Director had been in place since January 2021; the Chief of Staff described serving in the role since August 2018; and the ADPCS, who was the newest member of the team, was assigned in August 2024.



CULTURE

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. “Unsupportive, underdeveloped, or non-transparent” leaders contributed to organizations with “below-average performance in patient outcomes or quality of care metrics.”¹⁴ Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.¹⁵ The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA 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/VA_Community_Living_Centers.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. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization’s usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.¹⁷ By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA’s three HRO pillars.¹⁸

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In interviews, executive leaders described a severe weather event as a significant system shock.

Executive leaders shared that in October 2024, a tornado and a hurricane swept through the area, closing the outpatient clinics for a day. When an emergency occurs, the facility’s emergency communication system alerts staff with a prompt asking if they are safe, but the Chief of Staff said that not all staff responded to it. Executive leaders also said they called staff members who did not answer to ensure they were unharmed.

The Director told the OIG that after the weather event, leaders learned that some staff had not updated their contact information in the system, so they asked staff to do so to receive future notifications. During an interview, the OIG learned there were no staff or veterans injured due to the event. The ADPCS stated staff minimized disruptions to care by calling veterans promptly to reschedule appointments or offer them telehealth visits.

Leadership Communication

VHA’s HRO journey includes the operational strategy of organizational transparency.¹⁹ Facility leaders can demonstrate dedication to this strategy through “clear and open communication,” which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.²⁰ Additionally, The Joint Commission identifies communication between administrators and staff as one of the “five key systems that influence the effective performance of a hospital.”²¹

¹⁷ Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies.”

¹⁸ Vaughn et al., “Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies,” Department of Veterans Affairs, *VHA HRO Framework*.

¹⁹ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*, September 2022.

²⁰ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Enterprise Operating Plan Guidance (Fiscal Years 2023-2025)*; Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

²¹ The five key systems support hospital wide practices and include using data, planning, communicating, changing performance, and staffing. The Joint Commission, *Standards Manual*, E-dition, LD.03.04.01, January 14, 2024.

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.²² The survey scores for senior leader goal communication and information sharing improved from FY 2022 to FY 2024.²³ In interviews, executive leaders said they share information using multiple methods, such as visits to clinics and administrative departments, emails, and town hall events. The Director said leaders also produce short videos to spotlight different work areas and share them with staff, as well as post messages on social media about their positive effect on veterans' healthcare.

²² The All Employee Survey "is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential." "AES Survey History, Understanding Workplace Experiences in VA," VHA National Center for Organization Development.

²³ Senior leader goal communication measures leaders' communication of the organization's goals, and senior leader information sharing measures how satisfied staff are with the information received from leaders. "2024 VA All Employee Survey (AES) Questions by Organizational Health Framework," VHA National Center for Organization Development.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.²⁴ Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.²⁵ The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. Most respondents indicated they felt comfortable reporting safety concerns. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

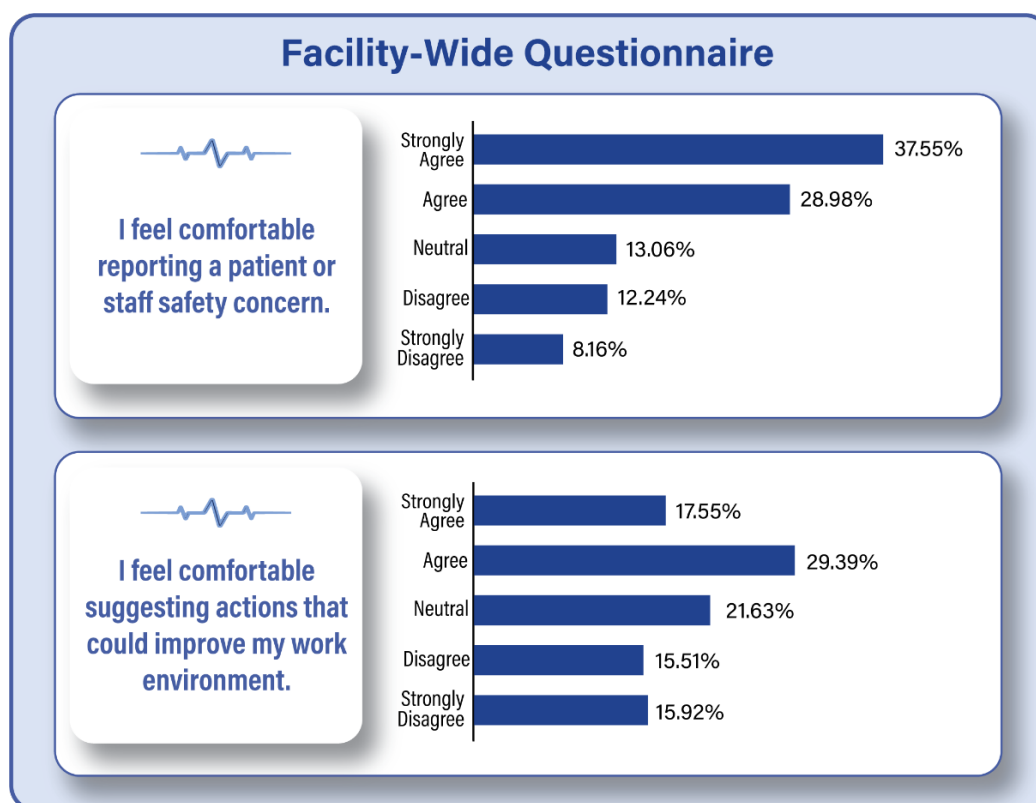


Figure 4. Employees' perceptions of facility culture.

Source: OIG questionnaire responses.

The OIG found that survey scores for the best places to work improved from FY 2022 through FY 2024. Executive leaders said employees are comfortable identifying themselves when they

²⁴ "Psychological safety is an organizational factor that is defined as a shared belief that it is safe to take interpersonal risks in the organization." Jiahui Li et al., "Psychological Safety and Affective Commitment Among Chinese Hospital Staff: The Mediating Roles of Job Satisfaction and Job Burnout," *Psychology Research and Behavior Management* 15 (June 2022): 1573–1585, <https://doi.org/10.2147/PRBM.S365311>.

²⁵ 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>.

report safety concerns and discussing ways to correct the situation. The Director said employees in different work areas present on patient safety issues monthly to encourage conversations among all employees throughout the facility.

Executive leaders identified their need to train frontline supervisors to improve employees' experiences. Therefore, they had experts teach supervisors team building skills. Leaders also met with supervisors to discuss their roles and any difficulties in their work areas.

Veteran Experience

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

In the OIG's questionnaire, a patient advocate indicated executive leaders are responsive to veterans' concerns and help quickly resolve issues. For instance, executive leaders told the OIG that after hearing numerous concerns regarding the phone system in 2023, they enhanced the secure messaging system to offer veterans another way to communicate with staff. The enhanced system reduced the number of incoming phone calls and improved staff's capacity to respond to veterans' needs. Executive leaders said they also implemented VA Health Chat, a mobile application veterans can use to schedule appointments, ask questions about their health, and request prescription medications.²⁸



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.²⁹ To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from

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

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

²⁸ "VA Health Chat," Department of Veterans Affairs, accessed January 21, 2025, <https://mobile.va.gov/health-chat>.

²⁹ VHA Directive 1608(1).

prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.³⁰ The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.³¹

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.

The OIG used a commercial navigation application to arrive at the facility's main entrance and found the directions easy to follow. The parking lots had ample lighting and sufficient spaces that included some accessible to those with disabilities.

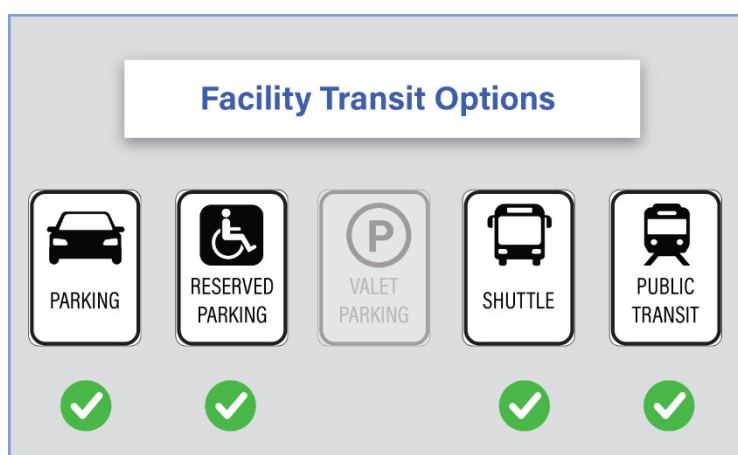


Figure 5. Transit options for arriving at the facility.
Source: OIG analysis of documents and interviews.

³⁰ 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>.

³¹ Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage Design Guide*, December 2012; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, January 2024; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Main Entrance



Figure 6. Facility front entrance.
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.³² The main entrance was clearly marked and had a patient loading zone with an overhang that protected veterans from inclement weather. After entering through power-assisted doors, the OIG found a clean, well-lit, and welcoming atrium with ample seating, and available wheelchairs. The atrium also contained a café where veterans could purchase snacks or coffee.

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.³³

In the atrium, the OIG also observed an information desk with staff and volunteers to help veterans find their way around, as well as wall-mounted maps and directional signs. During the physical inspection, the OIG was able to navigate to desired locations without difficulty.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory

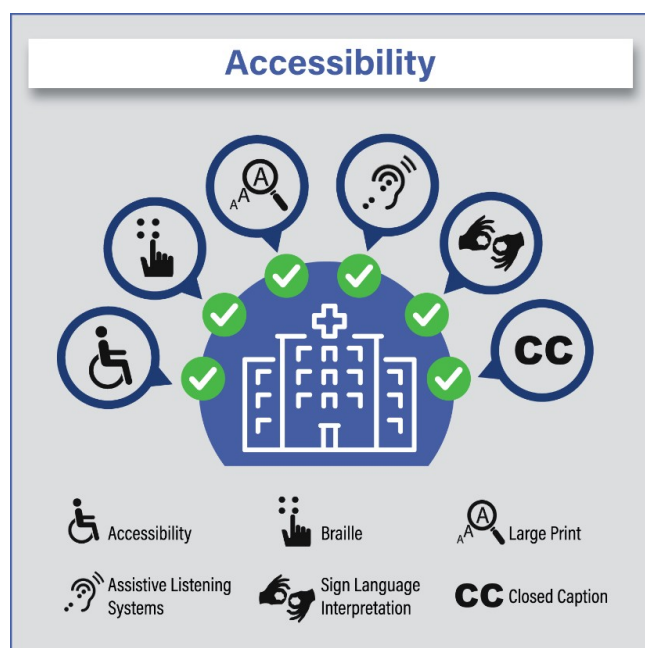


Figure 7. Accessibility tools available to veterans with sensory impairments.

Source: OIG observations and analysis of documents and interviews.

³² VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage Design Guide*.

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

impairments.³⁴ The staff and volunteers at the information desk explained they escort those with visual or hearing impairments to their destination as needed. The facility liaison reported assistive listening devices are available for hearing-impaired individuals, and the OIG noted braille on door signs and in elevators.

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.³⁵ When asked, information desk staff and volunteers could direct the OIG to the screening areas.

Prior to the site visit, the OIG received documentation that identified two toxic exposure screening navigators. One navigator described reviewing toxic exposure screenings every week to ensure clinical staff complete them timely. As a result of this practice, the navigator reported in January 2025 there were no unresolved screenings.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.³⁶ The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed Joint Commission and Annual Workplace Evaluation reports, which identified furniture stored in exit pathways, as well as expired cleaning wipes and hand sanitizer. The OIG did not find expired cleaning wipes or hand sanitizer and noted hallways and exits were clear and accessible.

The OIG reviewed documents and learned of the Comprehensive Environment of Care Committee's performance improvement plan to address environment of care inspectors'

³⁴ VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; "Best Practices Guide for Hospitals Interacting with People Who Are Blind or Visually Impaired," American Foundation for the Blind, accessed May 26, 2023, <https://www.afb.org/research-and-initiatives/serving-needs-individuals-visual-impairments-healthcare-setting>; Anjali Joseph and Roger Ulrich, *Sound Control for Improved Outcomes in Healthcare Settings*, The Center for Health Design Issue Paper, January 2007.

³⁵ Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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

excessive use of the miscellaneous finding category for deficiencies identified during inspections. The environment of care inspectors completed web-based and in-person training on the importance of selecting appropriate categories. Inspectors stopped using the miscellaneous category for all deficiencies, which allowed the committee to track issues by type, such as wall or floor damage. The committee monitored the issue monthly and by the end of FY 2024, staff had reduced the use of miscellaneous finding category to zero.

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 five patient care areas that were generally clean and without safety or privacy concerns. Although there was a ceiling leak in the community living center, the OIG noted staff had installed a ceiling barrier and caution signs on the floor to prevent injuries. Staff also provided the OIG with documentation of plans to resolve the issue; therefore, the OIG did not make a recommendation.



The OIG explored VHA facilities' patient safety processes. The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.³⁷ 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.³⁸ 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.

³⁷ VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

³⁸ Daniel Murphy, Hardeep Singh, and Leonard Berlin, "Communication Breakdowns and Diagnostic Errors: A Radiology Perspective," *Diagnosis* 1, no. 4 (August 19, 2014): 253-261, <https://doi.org/10.1515/dx-2014-0035>.

The OIG reviewed aggregated data from the year prior to the inspection to determine if providers communicated abnormal test results that required action to patients within seven days from when the result was available, as required.³⁹ The OIG found that for the last three months of the year, providers had communicated results to patients within the required time frame.

During an interview, clinical leaders said they developed service-level workflows that describe team member roles in the communication process, as required by VHA.⁴⁰ Leaders also stated they randomly review electronic health records to evaluate providers' compliance with VHA requirements and include this in their yearly performance evaluations. The Chief of Staff and ADPCS reported they also monitor providers' compliance with communicating test results to patients during Quality Patient Safety Committee meetings.

Action Plan Implementation and Sustainability

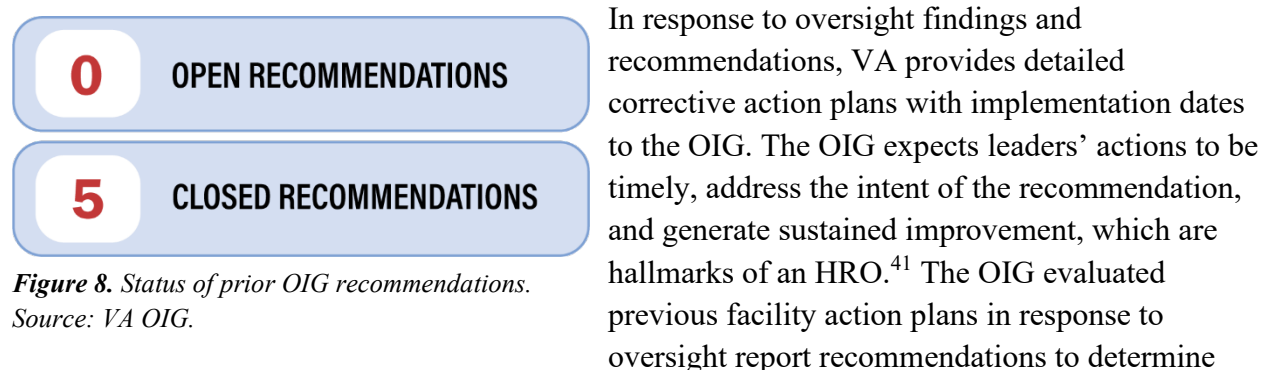


Figure 8. Status of prior OIG recommendations.
Source: VA OIG.

whether action plans were implemented, effective, and sustained.

The OIG reviewed previously published OIG reports and found no open recommendations.⁴² In an interview, quality management staff and the Chief of Staff explained that when an oversight agency issues a recommendation, they develop action plans to address it, update executive leaders at least monthly on any barriers to improvements, and report the outcome to the Quality Patient Safety Council monthly for oversight. The Associate Chief of High Reliability discussed

³⁹ VHA Directive 1088(1).

⁴⁰ VHA Directive 1088(1). Leaders discussed service-level workflows at the time of the inspection in January 2025, and staff submitted evidence of the workflows after the inspection.

⁴¹ VA OIG Directive 308, *Comments to Draft Reports*, April 10, 2014.

⁴² VA OIG, [Comprehensive Healthcare Inspection of the West Palm Beach VA Medical Center in Florida](#), Report No. 21-00272-283, September 29, 2021; VA OIG, [Inadequate Coordination of Care for a Patient at the West Palm Beach VA Healthcare System in Florida](#), Report No. 22-01594-86, March 30, 2023.

evaluating actions and outcomes to ensure sustained improvement. If outcomes do not improve, staff create another action plan and consider initiating a systems redesign project.⁴³

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.⁴⁴ 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.⁴⁵ The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In an interview, facility leaders explained that staff meet with leaders daily to discuss patient safety events. The Chief of Staff and Associate Chief of High Reliability review the events to identify opportunities for improvement. Quality management staff said they also examine peer reviews and electronic health records to identify performance improvement projects.⁴⁶ Quality management staff and the Patient Safety Manager reported they share lessons learned with staff through a newsletter, town halls, and monthly patient safety forums.

According to the Chief of High Reliability, executive leaders, service chiefs, and supervisors held a one-time, two-day event to identify process improvement opportunities. Once participants identified improvement initiatives, they created workgroups to develop an action plan to improve a deficient performance metric. Quality management staff then met regularly with the workgroups to track their progress and support them until the workgroups successfully implemented their plans and sustained improvement.

⁴³ Systems redesign and improvement is the practice of evaluating and analyzing "operational processes and procedures for the purpose of driving continuous improvement to increase/decrease output, increase efficiency, or increase the effectiveness of the process or procedure." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

⁴⁴ Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*.

⁴⁵ VHA Directive 1050.01(1).

⁴⁶ A peer review "is a critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190(1), *Peer Review for Quality Management*, November 21, 2018, amended July 19, 2024.



PRIMARY CARE

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.⁴⁷ 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 2033.⁴⁸ The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.⁴⁹ The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

Prior to the inspection, the facility liaison reported there were vacancies in 19 primary care positions: 5 registered nurse, 3 licensed practical nurse, and 11 medical support assistant positions. The Chief of Health Administrative Services stated that managers recently hired nine medical support assistants, but leaders have ongoing difficulties retaining them because they often leave for higher paying positions. The Chief Nurse of Ambulatory Care added that nursing has not experienced hiring challenges because the primary care work schedule, with no weekends or holidays, appeals to most candidates.

During an interview, the OIG learned there were also 6 vacant physician positions. The Chief of Primary Care described physician recruitment challenges that included the area's high cost of living and higher private sector salaries. To address these challenges, the chief said they hired candidates from medical schools, used national recruiter services, and offered an education debt reduction program.⁵⁰ During interviews, staff recalled hosting an open house to increase community awareness about positions that were challenging to recruit, such as medical support assistant positions that reportedly had low application rates because of low pay.

⁴⁷ VHA Directive 1406(2); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

⁴⁸ 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).

⁴⁹ VA OIG, [*OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2023*](#), Report No. 23-00659-186, August 22, 2023.

⁵⁰ The education debt reduction program provides financial assistance to eligible employees to offset student loan costs. VHA Handbook 1021.01, *Education Debt Reduction Program Procedures*, May 31, 2012.

The primary care team said current staffing levels allowed them to appropriately care for the patients on their panels. In addition, primary care leaders stated that due to a float pool of providers and nurses, primary care vacancies had no effect on clinic operations.⁵¹

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.⁵² The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.⁵³ The Patient Centered Management Module Coordinator reported meeting weekly with primary care leaders to review data to maintain panel sizes within VHA's baseline capacity of 1,200 patients for physicians and 900 for non-physicians.⁵⁴ The Primary Care Supervisory Management Analyst provided information showing that 82 percent of panels were within this baseline capacity.

To ensure patients had access to care, primary care staff said they added a Saturday clinic, and a schedule slot dedicated for new patients for each team; both helped decrease wait times for new patients from 23 days at the beginning of FY 2024 to 11 days at the end of FY 2024. The OIG also found appointment wait times for established patients ranged from 5 to 6 days.⁵⁵

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.⁵⁶ 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.

⁵¹ Float providers provide coverage for planned or unplanned primary care provider absences. VHA Handbook 1101.10(2).

⁵² "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

⁵³ VHA Directive 1406(2).

⁵⁴ The Patient Centered Management Module Coordinator manages staff and patient assignments for all primary care locations, and identifies the maximum panel capacity for the facility primary care teams. The maximum capacity is "the total number of patients that should be assigned to a team based on its station, care type, intensity score and rooms available at the station." VHA Directive 1406(2).

⁵⁵ VHA bases established wait times on the patient indicate date (PID), which "is the date the health care provider and Veteran agree is clinically indicated for care. In the absence of health care provider input, the PID is the Veteran's preferred date." VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. VHA bases new wait times on the reference date (RD), which "refers to a point in time. The wait time for new appointments from reference date (RD) is calculated from the appointment/create date, if the appointment is not linked to a consult, or the consult file entry date, if the appointment is linked to a consult." "Appointments Cube Dashboard," VHA Support Service Center.

⁵⁶ VHA Handbook 1101.10(2).

Primary care staff said they feel heard by their supervisors, value the frequent and open communication, and primary care leaders respond to their concerns. For example, primary care leaders increased new patient appointments from 30 to 60 minutes, which allowed more time for staff to complete their tasks, such as finishing clinical alerts (notifications in the electronic health record system), even if a patient arrived late. In addition to regular meetings to address staff's concerns, leaders issued a primary care newsletter to inform them about work schedules and other important issues that could affect workflow.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. Staff stated the act did not affect the teams' functioning or efficiency. The OIG found that veteran enrollment decreased slightly from FYs 2022 through 2024. The Chief of Staff attributed this to a decline in the elderly population, as well as veterans who relocated to areas north of West Palm Beach with a lower cost of living.

Executive and primary care leaders said they use outreach initiatives, such as paid advertising and town halls, to encourage veterans to enroll. Additionally, veteran enrollment specialists participate in events, and primary care nurses call veterans who previously received care at the facility to remind them of their VA care eligibility and reenroll them if possible. The ADPCS added that leaders plan to open a multispecialty clinic in June 2025 and an outpatient clinic in 2028 to accommodate veterans north of West Palm Beach should they reenroll for care.



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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.⁵⁷

⁵⁷ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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).⁵⁸ VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."⁵⁹

The program did not meet the target in FYs 2022 or 2024; however, it exceeded it in FY 2023. Program leaders cited staffing vacancies, which limited outreach, as a factor contributing to the missed targets. The Assistant Chief of Social Work attributed the success in FY 2023 to adequate staffing and outreach activities that year. The Homeless Services Section Chief added that during FY 2024, some program staff were reassigned to work in other areas. The section chief reported hiring two outreach staff that year; however, one of the new hires transferred to another position, and they were currently training the other. Additionally, the assistant chief said staff were developing a dashboard to monitor the targets and actions they took to meet them.

Program staff said they participated in the point-in-time count and received referrals from facility and community providers to identify homeless veterans. The Outreach Social Worker told the OIG that outreach efforts helped staff identify homeless veterans who believed they were ineligible for VA services. The assistant chief added that staff then worked with the eligibility department to enroll these veterans in the facility.

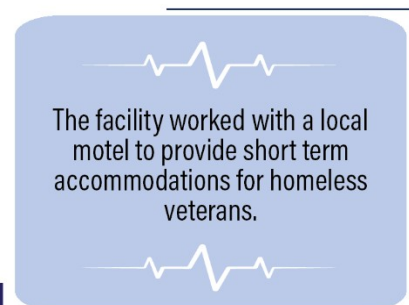


Figure 9. Best practice for meeting veteran needs.

Source: OIG interviews.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules...failure to comply with program requirements...or [who] left the program without consulting staff" (performance measure HCHV2).⁶⁰ The program did not meet the HCHV1 target for FY 2022 but exceeded it in FYs 2023 and 2024. The Homeless

⁵⁸ VHA sets targets at the individual facility level. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022.

⁵⁹ 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.

⁶⁰ VHA sets targets for HCHV1 and HCHV2 at the national level each year. For FY 2023, the HCHV1 target was 55 percent or above and the HCHV2 (negative exits) target was 20 percent or below. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

Services Section Chief discussed multiple factors that contributed to their success the last two years. The section chief said staff met regularly with veterans to discuss discharge planning from the program and helped them gain employment, which led to veterans finding permanent housing.

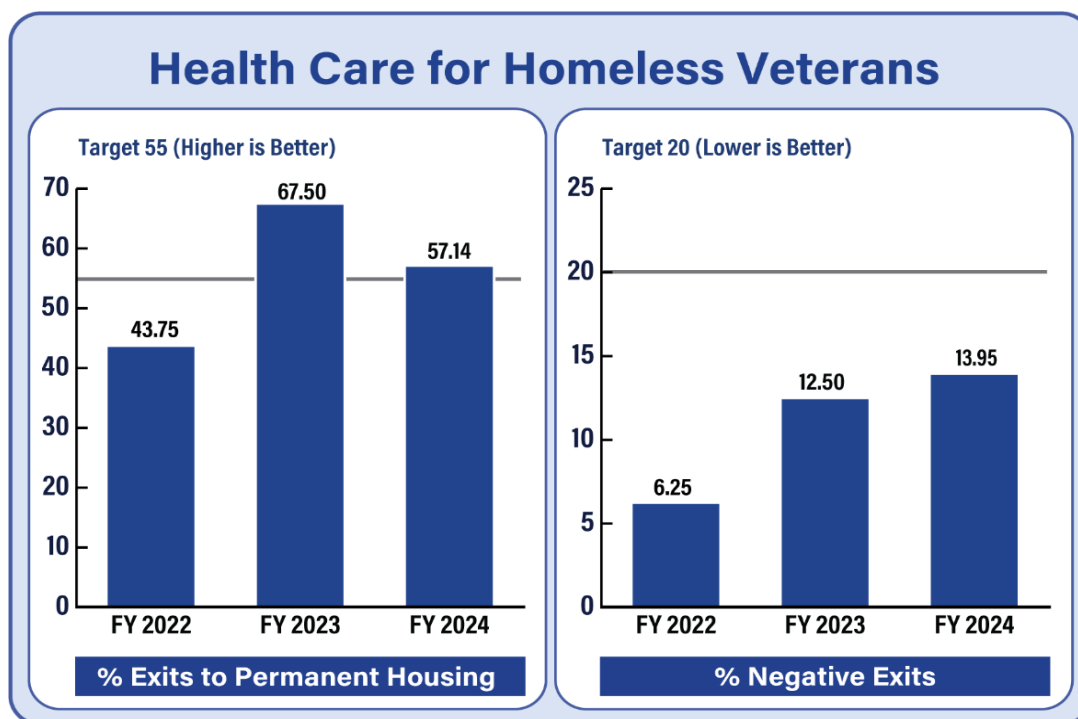


Figure 10. HCHV program performance measures.
Source: VHA Homeless Performance Measures data.

The program exceeded the HCHV2 target in FYs 2022 through 2024 by working with facility and community programs to identify resources for veterans, such as job opportunities, to increase housing options. In addition, the leaders informed the OIG they trained contract emergency residential services staff on how to assist veterans with their mental health disorders.⁶¹

The Outreach Social Worker informed the OIG that enrolled veterans had ongoing needs, such as housing assistance, transportation, and mental health treatment. Staff worked with the Supportive Services for Veterans and Families incentive program to provide landlords with additional funds

⁶¹ In addition to outreach services, HCHV programs include transitional housing and case management services through contracts with community providers. “Contract Emergency Residential Services (CERS) programs target and prioritize homeless Veterans who require safe and stable living arrangements while they seek permanent housing.” VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

for the first year’s rent and with facility and community partners to address veterans’ other ongoing needs.⁶²

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.”⁶³ 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.⁶⁴

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).⁶⁵ The program did not meet the target in FYs 2022, 2023, or 2024. Program leaders cited staffing shortages, high rental costs, and the lack of affordable housing as contributing factors. A program leader said after hiring an additional housing specialist, staff established relationships with more local landlords who wanted to work with the program to help meet the target.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of

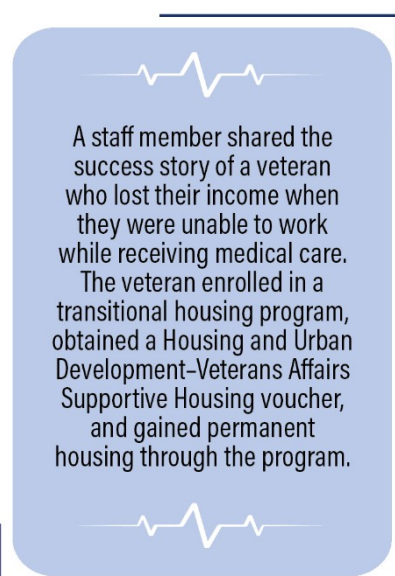


Figure 11. Program success story.
Source: OIG questionnaire response.

⁶² Supportive Services for Veteran Families provides case management to prevent homelessness, find more suitable housing, or rapidly re-house veterans. “Supportive Services for Veteran Families,” Department of Veterans Affairs, accessed August 14, 2024, <https://www.va.gov/homeless/ssvf/index.html>.

⁶³ VHA Homeless Programs Office, *Fiscal Year 2022 Annual Report*.

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

⁶⁵ VHA sets the HMLS3 target at the national level each year. The FY 2023 target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

each month (performance measure VASH3).⁶⁶ The program met the target in FY 2022 but not in FYs 2023 and 2024.

Program leaders found staff had not updated veterans' employment status in the national homeless database. Program leaders addressed this by implementing spot checks to ensure staff regularly updated employment status in the database moving forward.

Program leaders said veterans enrolled in the program needed mental health, substance abuse and medical treatment, as well as assistance with transportation, furniture, finances, education, employment, technology (using computers to search for online documents), and legal matters. Leaders said program staff coordinated with community partners and facility staff to address unmet needs. For example, local retail stores provided bicycles for veterans to ride to work and new cribs for expectant mothers.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."⁶⁷ Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.⁶⁸

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).⁶⁹ The facility's program exceeded the target during FYs 2023 and 2024. Program staff attributed their success to working together as a team; attending outreach events; and collaborating with the legal aid clinic, where lawyers offer free legal services to veterans at the facility. Staff also trained first responders about the program to encourage them to send veterans with mental health and substance use disorders to treatment instead of jail.

A staff member stated that 98 percent of veteran graduates from the veterans treatment courts (which offer treatment programs as alternatives to incarceration) did not re-offend.

Figure 12. Veterans Justice Program success.

Source: OIG interviews.

⁶⁶ 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*.

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

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

⁶⁹ VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

Meeting Veteran Needs

Program staff said veterans enrolled in the program needed housing, mental health, financial, employment, transportation, and medical assistance. Program staff worked with facility and community partners to address these needs, such as by helping veterans obtain medical appointments.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and did not make any recommendations. Recommendations do not reflect the overall quality of all services delivered within the facility. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.¹ The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to multiple VSOs. Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*.²

Potential limitations include self-selection bias and response bias of respondents.³ The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel discussion; the OIG requested this selection to minimize the impact of the OIG inspection on patient care responsibilities and primary care clinic workflows.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from January 14 through 16, 2025. During site visits, the OIG refers concerns that are beyond the scope of the inspections to the OIG's hotline management team for further review.

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

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.⁴ The OIG reviews available evidence within a specified

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

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

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

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

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

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

Appendix B: Facility in Context Data Definitions

Table B.1. Description of Community*

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

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

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

Table B.2. Health of the Veteran Population*

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

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

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

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 8, 2025

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

Subj: Healthcare Facility Inspection of the West Palm Beach VA Healthcare System in Florida

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

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

1. I have reviewed the draft report from OIG's Healthcare Facility Inspection of the West Palm Beach VA Healthcare System, West Palm Beach, Florida.
2. I concur in expressing gratitude to the OIG for their partnership in our commitment to the principles and practices of a high reliability organization.
3. Thank you for the opportunity to review and respond to this report.

(Original signed by:)

David Dunning, MPA

Interim VISN 8 Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 29, 2025

From: Director, West Palm Beach VA Healthcare System (548)

Subj: Healthcare Facility Inspection of the West Palm Beach VA Healthcare System in Florida

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

I have reviewed the Office of the Inspector General's (OIG) report and concur with their conclusions. I appreciate the partnership with the OIG in ensuring the Veterans we proudly serve can continue to expect exceptional health care services.

(Original signed by:)

Cory P. Price, FACHE

Executive Director

West Palm Beach VA Healthcare System

OIG Contact and Staff Acknowledgments

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