US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Miami VA Healthcare System in Florida

Healthcare Facility Inspection	25-00196-05	November 19, 2025

OUR MISSION

To conduct independent oversight of the Department of Veterans Affairs that combats fraud, waste, and abuse and improves the effectiveness and efficiency of programs and operations that provide for the health and welfare of veterans, their families, caregivers, and survivors.

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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 Miami VA Healthcare System (facility) from February 10 through 13, 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. Executive leaders identified employee turnover and space and funding limitations as system shocks. To address turnover, leaders said they use incentives to attract new staff and retain current staff. They also reported a desire to increase facility services but noted barriers to expansion such as limited space at the main site and rising construction costs.

The facility's All Employee Survey scores for communication, information sharing, and transparency were consistently above VHA averages from fiscal years 2022 through 2024.[2] Executive leaders attributed this to their focused interactions with service-level leaders and

[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.

[2] 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.

frontline staff at all locations, both in-person and virtually, and during town halls and daily tiered huddles.[3]

In addition, the facility's survey scores for best places to work, no fear of reprisal, and psychological safety for fiscal years 2023 and 2024 also met or exceeded VHA averages. Since embracing high reliability organization principles over the past year, leaders stated employees had become more willing to report concerns. Most respondents to an OIG-administered questionnaire agreed they felt comfortable suggesting improvements and reporting safety concerns. Leaders also review patient advocate reports each day to ensure employees address veterans' complaints promptly.

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 easily accessible to veterans with sensory impairments with a welcoming and comfortable entrance area. Patient care areas were clean and free of privacy concerns. However, the OIG identified several problems with the facility's environment of care.

Facility staff did not address environment of care deficiencies within 14 days or develop an action plan to address them, as required by VHA.[4] Staff also did not have a consistent preventive maintenance schedule for medical equipment; some maintenance was overdue for two years. Additionally, the OIG noted cleaning supplies in a soiled utility room, expired medical supplies, undated patient food items in food storage areas, and multiple storage areas without signs on doors. The OIG made five recommendations. The Director responded to the recommendations and reported staff addressed key deficiencies and will closely monitor corrective actions and progress. Leaders implemented an updated standard operating procedure to provide step-by-step guidance on preventive maintenance for medical equipment. Staff posted signs outside all housekeeping closets and are developing new standardized signs for medical storage and supplies. Staff also removed expired medical supplies and food and implemented unit inspections to monitor compliance (see OIG Recommendations and VA Responses).

[3] Tiered huddles, used from frontline staff to senior leaders, are brief, focused meetings 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 (March 21, 2022): 901-906, https://pmc.ncbi.nlm.nih.gov/articles/PMC9383570/.

[4] Office of the Chief Officer, Support Operations (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Compliance Report Survey (VIEWS 12688127)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), February 12, 2025.

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 the facility had processes to communicate test results to providers who order tests, identify a surrogate when the provider was unavailable, and communicate results outside regular clinic hours. An interview panel, consisting of the Chief of Staff, Chief of Informatics, and quality management staff, told the OIG the facility uses an electronic application on VA smart phones and computers to display a cascade (notification list) of providers for staff to contact with results if the provider who ordered the test is not available.

The OIG found the facility had no open recommendations from previous oversight reports. Staff explained that for any findings or recommendations, they track action plans, then monitor the change for six months to ensure sustained improvements. They also said executive leaders supported process improvement projects, and quality management staff did not identify any barriers to long-term patient safety improvements.

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

Although the facility had a shortage of primary care providers, nurses, and medical assistants, the OIG found patients did not experience increased appointment wait times or care delays because leaders added float providers (providers not assigned to a team) and a walk-in time slot to all clinic schedules to ensure patients had access to care. Primary care team members stated leaders were accessible and helped them improve efficiency, decrease workload, and share information. Primary care leaders and staff added that overall enrollment remained the same following the PACT Act, and although they enrolled new patients, others moved out of the service area.

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. Homeless program staff reported they conduct outreach activities and receive referrals in various ways to enroll veterans in programs for healthcare, housing, and legal and financial services. Staff noted

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

the importance of working closely with community partners to meet veterans' needs, such as education and vocational training.

In addition, the Housing and Urban Development–Veterans Affairs Supportive Housing program uses the One Team Approach in working with veterans.[6] Staff said this has helped lower barriers to accessing housing resources.

What the OIG Recommended

The OIG made five recommendations.

1. The Executive Director ensures staff address environment of care deficiencies within 14 days or have an action plan, as required.
2. The Executive Director ensures staff perform preventive maintenance on medical equipment in accordance with manufacturers' recommendations.
3. The Executive Director ensures staff evaluate the best place to store cleaning supplies, staff store them there, and leaders monitor compliance.
4. The Executive Director ensures staff remove expired medical supplies and patient food items from patient care areas.
5. The Executive Director ensures doors in patient care areas have signs to indicate what is stored inside.

[6] In the One Team Approach, VA and community programs work together to address homelessness within a community. "VA Homeless Programs," Department of Veterans Affairs, accessed February 12, 2025, https://www.va.gov/homeless/oneteam-toolkit.asp.

VA Comments and OIG Response

The interim Veterans Integrated Service Network Director and interim facility Director concurred with our inspection findings and recommendations and provided acceptable improvement plans, and leaders are implementing corrective actions (see OIG Recommendations and VA Responses). The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

Miami VA Healthcare System
Miami, Florida
Level 1b-High Complexity
Miami-Dade County
Hospital Referral Region: Miami

Description of Community

POPULATION

Female **2,429,025**	Male **2,310,283**
Veteran Female **17,209**	Veteran Male **133,986**

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

MEDIAN INCOME

$63,901

EDUCATION

89% Completed High School
63% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **431**

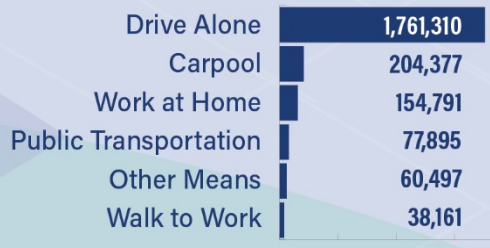
SUBSTANCE USE

13.5% Driving Deaths Involving Alcohol
22.3% Excessive Drinking
1,037 Drug Overdose Deaths

UNEMPLOYMENT RATE

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

TRANSPORTATION



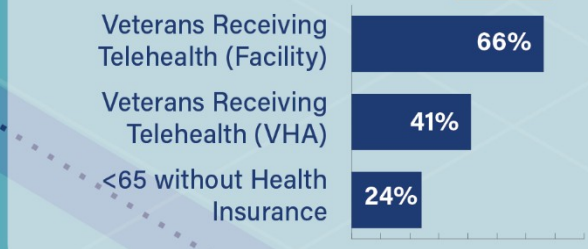
AVERAGE DRIVE TO CLOSEST VA

Primary Care	**13 Minutes, 8 Miles**
Specialty Care	**34 Minutes, 30 Miles**
Tertiary Care	**34 Minutes, 30 Miles**

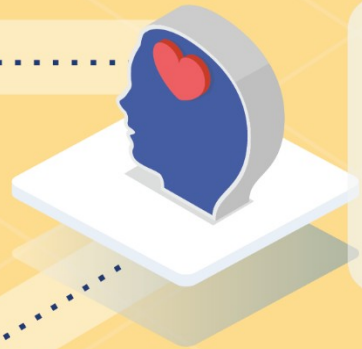
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **34,702**



Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

18,825

199 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.14 Days

30-DAY READMISSION RATE

10%

SUICIDE RATE PER 100,000

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

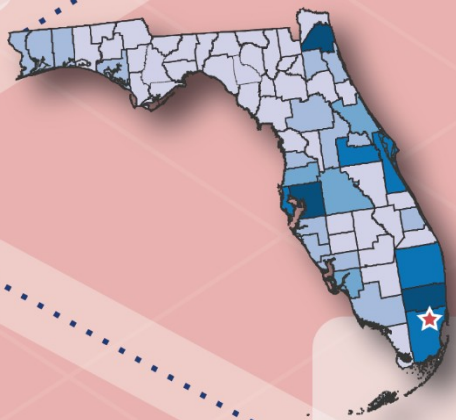
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	61K
Unique Patients VA Care	59K
Unique Patients Non-VA Care	14K

COMMUNITY CARE COSTS

Unique Patient $14,244	Outpatient Visit $308
Line Item $517	Bed Day of Care $270



STAFF RETENTION

Onboard Employees Stay <1 Yr	7.68%
Facility Total Loss Rate	12.11%
Facility Retire Rate	2.28%
Facility Quit Rate	9.15%
Facility Termination Rate	0.61%

★ VA MEDICAL CENTER

VETERAN POPULATION

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

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

Contents

Background and Vision

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

The OIG established the Healthcare Facility Inspection 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.

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

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.

[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]

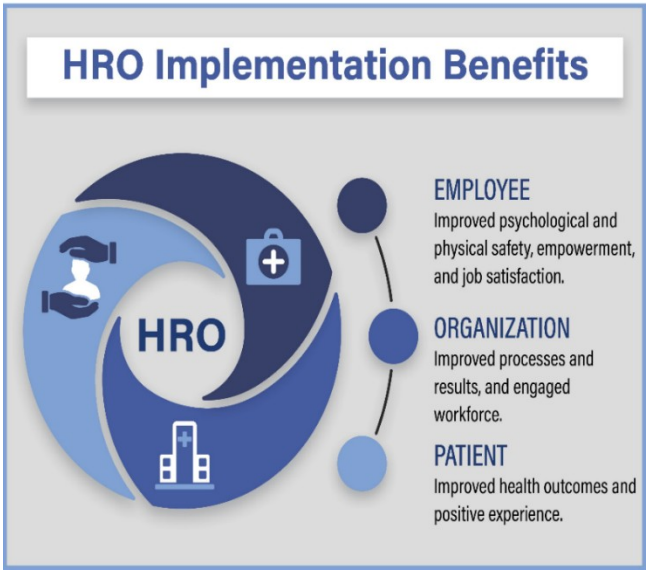


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

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

[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 Miami VA Healthcare System (facility) opened in 1968. In fiscal year (FY) 2024, the facility provided care to 58,143 patients and had 315 operating beds (176 hospital, 29 domiciliary, and 110 community living center beds).[13] The facility's FY 2024 medical care budget was $923,866,373. In addition to the main site in Miami, the facility has eight community-based outpatient clinics.[14]

The OIG inspected the facility from February 10 through 13, 2025. According to facility documents, the executive leaders consisted of the Executive Director (Director); Associate Director; Assistant Director for Employee and Veteran Experience; Chief of Staff; Associate Director, Patient Care Services; interim Deputy Director; and interim Assistant Director for Business Strategy. The executive leadership team had worked together since December 2024, when the interim Deputy Director was temporarily assigned to the position.

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."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] 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

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed February 12, 2025, https://www.va.gov/homeless/dchv.asp. "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_CLC.asp.

[14] The facility's outpatient clinics are located in Deerfield Beach, Flagler, Hollywood, Homestead, Key Largo, Key West, Pembroke Pines, and Sunrise, Florida.

[15] 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.

[16] Stephen Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*, Institute for Healthcare Improvement White Paper, 2013.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[17]

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.[18] 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.[19]

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, executive leaders discussed high employee turnover and space and funding limitations as system shocks.

The leaders attributed turnover rates to salaries that did not meet the area's high cost of living, which caused many employees to live outside the city where housing is more affordable and resulted in long commutes to work. Leaders also identified that higher salaries offered at other Miami-area healthcare systems contributed to difficulties with employee recruitment and retention; however, their use of incentives, such as student loan repayments, have improved retention.

Leaders shared a desire to increase and enhance patient care services at the main site and some community-based outpatient clinics; however, there is limited space to expand at the main site, and the cost per square foot for property in the Miami area is high. Leaders asserted that they approved projects to expand space at some community-based outpatient clinics but acknowledged that the work may take years to complete, and costs are expected to increase over time. Leaders also said they struggled to hire contractors for projects due to the long wait time for funds that can be allocated for them.

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,"

[17] 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.

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

[19] 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*.

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

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]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with employees, and shared information.[23] The facility's survey scores for communication, information sharing, and transparency either improved or stayed about the same from FY 2022 through FY 2024, and they were consistently above VHA averages. During the interview, executive leaders attributed the scores to them visiting all units regularly, and employees using tiered huddles daily to share information.[24] Additional communication efforts include display boards on each unit to show accomplishments, shared safety stories and patient satisfaction feedback; monthly Director Listening Post events where employees can meet with the Director; and weekly town halls with live open chats where employees can provide feedback.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

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[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 frontline 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 (March 21, 2022): 901-906, https://pmc.ncbi.nlm.nih.gov/articles/PMC9383570/.

[25] "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.

[26] 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.

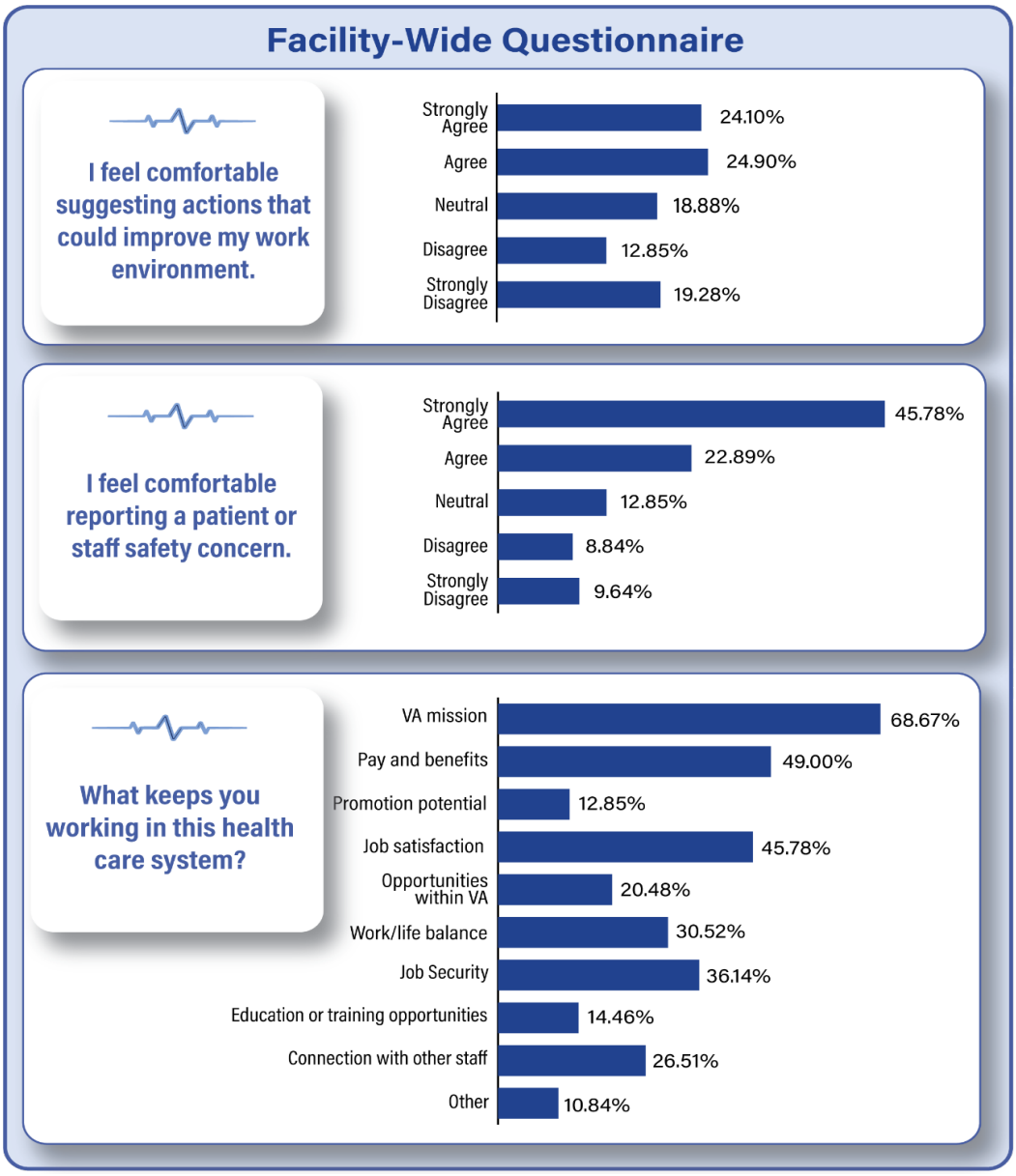

Figure 4. *Employee perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The OIG found survey scores for best places to work, no fear of reprisal, and psychological safety in FYs 2023 and 2024 were equal to or higher than VHA averages. Leaders said they track survey scores per unit and if the scores do not improve, they try to understand the employees' concerns and address them. Leaders also said employees' interactions have changed over the past year; employees were previously apprehensive about reporting concerns or suggesting ways to improve services but are now willing to communicate openly with leaders. Leaders attributed the change to embracing HRO principles, being present in the different areas, and attending events throughout the facility.

Leaders said employees appear committed to their positions and to the VA mission. OIG questionnaire respondents largely indicated the VA mission, pay and benefits, and job satisfaction kept them at the facility. In addition, most felt comfortable suggesting ways to improve their work environment and reporting safety concerns. This supports statements made by executive leaders and demonstrates that employees feel psychologically safe in their work environment.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[27] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

Patient advocates identified the most common complaints as difficulty getting clinic staff to answer the phone and long wait times for appointments. Executive leaders said they review patient advocate reports daily to ensure staff address complaints, and all agreed the goal is to resolve them as quickly as possible. Patient advocates reported in an OIG-administered questionnaire that facility leaders are responsive to veterans' concerns.

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

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[28] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 5. *Bruce W. Carter Department of Veterans Affairs Medical Center part of the Miami VA Healthcare System. Source: "VA Miami Healthcare," Department of Veterans Affairs, accessed April 23, 2025, https://www.va.gov/miami-health-care/.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[29] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[30]

[28] VHA Directive 1608(1).

[29] Roger S. Ulrich et al., "A Review of the Research Literature on Evidence-Based Healthcare Design," *HERD: Health Environments Research & Design Journal* 1, no. 3 (Spring 2008): 61-125, https://doi.org/10.1177/193758670800100306.

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

Transit and Parking

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

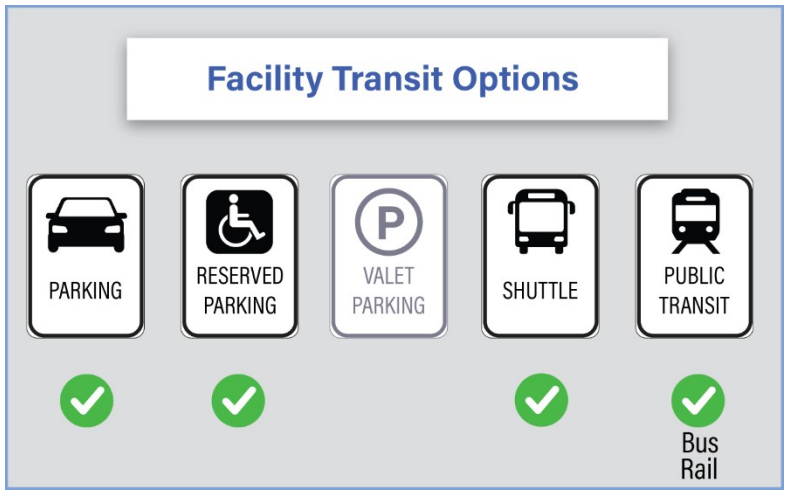

Figure 6. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

Facility leaders provided information about parking and transit services at the facility. Based on documents and observations, the OIG found public bus and rail transit services available at least three times a day within one block of the main site. At the main site and the Sunrise community-based outpatient clinic, volunteer-run shuttles operate during business hours to take veterans to and from the buildings and their vehicles. The OIG noted the facility had adequate parking, and the parking lots were well lit, with emergency call buttons, cameras, and a security guard station to ensure safety for veterans and employees.

Main Entrance

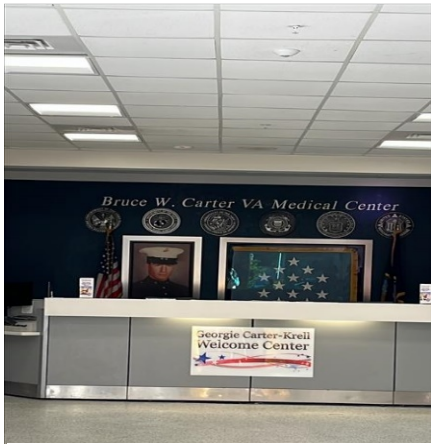

Figure 7. *Facility main entrance.*
Source: Photo taken by OIG inspector.

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.[31]

The OIG used the navigation link on the facility's public website to easily reach the facility and identify the main entrance. Once on-site, the OIG found clear and easy-to-read directional signs for parking. At the main entrance, the OIG noted a passenger loading zone with a weather-protection canopy, along with power-assisted sliding doors. Inside the well-lit entry area, there was an information desk with pamphlets of available services and upcoming events, as well as a seating area and café where veterans can socialize.

[31] 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*.

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.[32]

The OIG observed a volunteer at the information desk and another at the main entrance who directed veterans to their destinations or called escort staff when needed. The OIG also noted color maps with easy-to-read, clearly marked, and labeled buildings. Overall, the OIG found the facility easy to navigate.

Figure 8. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and observations.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[33] The OIG observed wall-mounted maps with large fonts, braille at hallway intersections as well as in elevators with audible cues for each floor. In a questionnaire and instant message response from the facility liaison, the OIG learned the facility offers sign language interpreter services and assistive listening devices, such as personal amplifiers, to veterans upon request. Veterans can also receive talking blood pressure monitors, glucometers, and devices that read prescription labels for home use.

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.[34]

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[32] VHA Directive 1850.05; 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*; "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.

[34] 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.

In response to the OIG questionnaire, a staff member indicated the facility has three toxic exposure screening navigators, but the role is an additional duty. A navigator reported having adequate resources to carry out their duties, and that primary care staff performed most of the screenings. Further, a navigator explained that staff initially screened veterans during primary care appointments and providers completed secondary screenings when needed. While on-site, the OIG found information desk staff would direct veterans to the primary care team for written information on toxic exposures and screenings.

The OIG reviewed toxic exposure screening reports and found the facility had over 220 overdue, unresolved secondary screenings on February 4, 2025; however, as of March 11, 2025, this number had decreased to 15. Therefore, the OIG made no recommendation.

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.[35]

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 found that in FY 2024 and the first quarter of FY 2025, staff did not meet the target for closing environment of care deficiencies within 14 business days or developing an action plan to address them.[36] In an interview, Comprehensive Environment of Care Committee leaders attributed this to position vacancies, including the chief of safety position, and not having a uniformed process to enter the deficiencies into the tracking system. Leaders said they now issue iPads to all participants to use during rounds to improve documentation and efficiency.

Committee leaders explained that when they identify deficiencies during inspections, they discuss the issue, educate staff on how to enter a work order, and rely on them to develop an action plan. Leaders also said they did not have the correct point of contact for every unit, so there were delays in staff returning action plans. They have since started to correct this issue and identify a point of contact for every unit. However, committee leaders said staffing shortages delayed them with completing work orders.

The OIG recommended the Director ensures staff address environment of care deficiencies within 14 days or have an action plan, as required. In response to the recommendation, the

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

[36] Office of the Chief Officer, Support Operations (19), "For Action: Fiscal Year 2024 Comprehensive Environment of Care Compliance Report Survey (VIEWS 12688127)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), February 12, 2025.

Director reported staff corrected key deficiencies and implemented the Performance Logic system to closely monitor corrective actions and progress (see OIG Recommendations and VA Responses).

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 found the facility to be clean and without privacy concerns, such as unattended protected patient information, but identified multiple opportunities for improvement.

First, the OIG noted that preventive maintenance stickers on multiple pieces of equipment were not up to date, and some stickers indicated inspections were two years overdue. Facility policy requires staff to perform preventive maintenance in accordance with manufacturers' recommendations and label equipment with the reinspection due date.[37] The OIG would expect preventive maintenance to be current to ensure equipment is working as it should be. Environment of Care Committee leaders attributed the outdated inspections to limited staffing.

The OIG recommended the Director ensures staff perform preventive maintenance on medical equipment in accordance with manufacturers' recommendations. The Director responded to the recommendation and reported staff updated a standard operating procedure that now provides step-by-step guidance on preventive maintenance for medical equipment (see OIG Recommendations and VA Responses).

Second, the OIG observed environmental management services' cleaning supplies stored in soiled utility rooms. The Joint Commission requires hospital staff to implement infection prevention and control activities when storing medical equipment, devices, and supplies.[38] Cleaning supplies should be stored independently of both the clean and soiled utility rooms to avoid risk of infection or contamination. Although staff removed the cleaning supplies the same day, the OIG reinspected one area the following day and again found cleaning supplies in the soiled utility room.

The OIG recommended the Director ensures staff evaluate the best place to store cleaning supplies, staff store them there, and leaders monitor compliance. In response to the recommendation, the Director stated staff placed signs outside all housekeeping closets and

[37] Miami VA Healthcare System, "Equipment Management Program" (standard operating procedure), January 14, 2025.

[38] The Joint Commission, *The Joint Commission Guide to Reprocessing Reusable Medical Devices*, 2023.

supervisors inspect the rooms daily to ensure staff have properly stored items (see OIG Recommendations and VA Responses).

Third, the OIG observed expired medical supplies, including disinfectant wipes, stored in clinical areas. Additionally, the OIG found undated and expired food items, such as crackers and pudding, in a patient nutrition room. VHA requires staff to inspect shelves and bins weekly for expired or outdated items.[39] Expired supplies and food items pose a health risk to patients.

The OIG recommended the Director ensures staff remove expired medical supplies and patient food items from patient care areas. The Director responded to the recommendation and reported staff implemented a bagging and labeling system for single serve items, and began inspecting unit pantries for expired items and to verify cleanliness (see OIG Recommendations and VA Responses).

Finally, the OIG identified multiple rooms in patient care areas that did not have signs on doors, including biohazard warning signs, to indicate what items were stored inside the room. The Joint Commission requires hospitals to maintain a safe environment.[40] When doors lack appropriate signs, staff may place clean and soiled items together in one room.

The OIG recommended the Director ensures doors in patient care areas have signs to indicate what is stored inside. In response to the recommendation, the Director described plans for standardized storage signs (see OIG Recommendations and VA Responses).

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.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between

[39] VHA Directive 1761, *Supply Chain Management Operation*s, December 30, 2020.

[40] The Joint Commission, *Standards Manual,* E-dition, EC.02.06.01, accessed June 16, 2025.

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

diagnostic and ordering provider teams and their patients.[42] 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 found the facility has processes to communicate abnormal results to providers, to identify a surrogate provider when the provider who ordered the test is unavailable or has left the facility, and to communicate results outside regular clinic hours. The Chief of Staff, Chief of Informatics, and quality management staff told the OIG that when the provider who ordered the test is not available, staff use an application that displays a cascade list with providers' contact information to escalate the notification. Facility staff first notify the designated surrogate provider, but if they are not available, staff continue to follow the list to contact other designated providers.

Staff can access and update the providers' contact list in real time using the application from a personal or VA-issued cell phone or a computer. The Chief of Staff, Chief of Informatics, and quality management staff said the cascade lists ensures staff know who to contact when the provider is unavailable.

The Chief of Staff identified a potential barrier to communicating test results to homeless patients due to the lack of contact information. In those situations, providers try to schedule follow-up appointments to discuss the test results before the patient leaves the facility after the test, or they seek assistance from social workers to reach the patients.

The Chief of Staff, Chief of Informatics, and quality management staff also identified electronic health record alert fatigue as a potential barrier to communicating results.[43] When alert fatigue occurs, a provider may fail to notify patients of test results. In response to possible alert fatigue, the Chief of Informatics explained that providers receive alert management training during new employee orientation. Informatics staff also share tips and tricks and train providers on basic settings for electronic health record alerts as needed.

Further, the Chief of Informatics said informatics staff monitor alerts to ensure providers respond timely. Three times a week, informatics staff notify providers and their supervisors if they have any unprocessed critical alerts. Informatics staff also notify providers and their supervisors weekly if they exceed 250 unprocessed alerts. The Chief of Informatics and quality management

[42] 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.

[43] Alert fatigue occurs when providers "become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings." "PSNet Patient Safety Network, Alert Fatigue," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/alert-fatigue.

staff explained that a staff member also monitors providers' compliance with communicating results timely through the External Peer Review Program.[44]

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.[45] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine if action plans were implemented, effective, and sustained.

The OIG reviewed a report and survey involving the facility for the past three years and did not find any open recommendations. The Chief of Staff, Chief of Informatics, and quality management staff confirmed the facility had no repeat findings. They added that if they have repeat findings, quality management staff share the information with executive leaders.

They further explained that quality management staff maintain an action plan document and track the actions until staff complete them to ensure they resolve findings or recommendations. They then monitor the actions for at least six months to ensure staff sustain improvements. Quality management staff said they did not identify any barriers to facility leaders and staff making long-term improvements 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.[46] 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.[47] 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, Chief of Informatics, and quality management staff reported that executive leaders support process improvement projects and did not identify any barriers for staff initiating projects. Quality management staff meet with executive leaders monthly to discuss patient safety

[44] VHA established the External Peer Review Program communicating test results measure as a way for facility leaders to review compliance with the timeliness of communicating test results and ensure "corrective action is taken when non-compliance is identified." VHA Directive 1088(1).

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

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

[47] VHA Directive 1050.01(1).

trends and review the Joint Patient Safety Reporting system to identify opportunities for improvement.[48]

Additionally, the Chief of Informatics shared several improvement projects, including efforts to reduce 30-day readmission and mortality rates and to improve quality of care. The Chief of Staff and quality management staff described the Chief of Informatics as efficient with data analysis and passionate about educating staff on their role in improving patient care and outcomes. Those interviewed also said staff use a variety of communication methods, for example daily announcements and town halls, to share patient safety stories, lessons learned, and improvements throughout the facility.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[49] 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.[50] 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.[51] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

The OIG reviewed a facility-provided list of vacancies in primary care positions and noted shortages for two providers, four registered nurses, four licensed practical nurses, and four medical assistants. The OIG also reviewed primary care administrative data and found that the number of primary care providers decreased from the second quarter of FY 2022 through the

[48] The Joint Patient Safety Reporting (JPSR) system is a database used at VA facilities to report patient safety events, such as adverse events and close calls. VHA National Center for Patient Safety, *JPSR Guidebook*, December 2023.

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

[50] 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).

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

fourth quarter of FY 2024.[52] Primary care leaders reported 30 providers left the facility during the past two-and-a-half-years due to the COVD-19 pandemic, retirement, or more competitive offers at other facilities. The loss contributed to an increased workload for the remaining providers. Providers reported that facility leaders leveraged other staff, such as clinic pharmacists and nurse care managers, to distribute the workload.

Leaders also said they conducted a salary market analysis, consulted with human resources staff to review facility versus community salaries, and received approval from the Director to increase pay for registered nurses, licensed practical nurses, and medical assistants. In addition, leaders offered staff student loan repayment opportunities; providers also received retention bonuses. These actions helped to mitigate the challenges and kept the facility competitive in the local job market. Leaders also acknowledged the difficulties they faced in 2024 when VHA limited hiring.[53] Leaders noted that although they are authorized to fill some vacancies, it will not be enough to make their staffing ratios compliant with the primary care team model.

Primary care staff and leaders stated that staffing shortages did not affect appointment wait times because they took several actions to maintain patients' access to care. For example, leaders added a walk-in time slot to all clinic schedules, and float providers (providers without a dedicated patient panel) worked in the advance care (same day) access clinics. Staff provided data showing the average wait time for new patients was 15.8 days, and for established patients, it was 5.6 days, which were within VHA's guidelines.[54]

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]

Primary care panel data also indicated some panel sizes were consistently greater than 90 percent capacity. In interviews, primary care leaders said they dissolved two primary care teams and redistributed patients among remaining teams to meet VHA's recommended baseline capacity of

[52] Staffing ratios refer to the number of recommended full-time equivalent support staff to one full-time equivalent primary care provider. The VHA primary care team model recommends a 3:1 ratio of three support staff to one provider. VHA Handbook 1101.10(2).

[53] Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Services Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024.

[54] Assistant Under Secretary for Health, Office of Integrated Veteran Care (IVC) (16), "Veteran Appointment Scheduling and Community Care Wait Time Eligibility (VIEWS#08891707*)*," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23) Medical Center Directors (00), November 18, 2022.

[55] "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).

[56] VHA Directive 1406(2).

1,200 patients.[57] Primary care staff told the OIG this redistribution temporarily increased their workload and led to longer appointment wait times, but it eventually improved. This approach helped leaders distribute workload equitably to prevent staff burnout. Despite panel sizes, primary care staff stated they managed their workload, especially with the support provided by other team members.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[58] 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 told the OIG that facility and primary care leaders were accessible, supportive, and frequently worked with them to find ways to improve efficiency. Primary care leaders explained that All Employee Survey results indicated opportunities for improvement, such as decreasing workload and improving communication with staff. They increased their use of virtual clinics, which accounts for 25 percent of the care they provide. They also received national recognition for being a leader in virtual care.

Additionally, leaders said they created a clinic tracking board (superboard) for staff to update patient information in real time. They encouraged primary care team members to present on best practices and created an online platform for staff to provide weekly continuing peer education. According to staff, these sessions cover a range of topics and have been very beneficial. They added that they are satisfied with leaders' engagement and how they address staff members' needs.

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. Based on an interview with executive leaders and a review of patient advocate responses to the OIG-administered questionnaire, staff and veterans had no concerns with the PACT Act.

Primary care team members acknowledged an influx of veterans following the PACT Act. Primary care leaders reported averaging approximately 500 to 550 new veterans each month, but

[57] "The modeled panel capacity is the maximum number of patients a PACT [Patient Aligned Care Team] is expected to care for when the baseline capacity, which is currently 1200, is adjusted by a formula that takes into account the current teamlet support staff, rooms, female veterans, intensity score, and PCP [Primary Care Provider] type." VHA Directive 1406(2).

[58] VHA Handbook 1101.10(2).

the facility's net growth remained unchanged because other veterans also moved out of the service area due to increased living costs.

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.[59]

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).[60] 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."[61]

The facility met the target for FY 2024.[62] Leaders attributed meeting the target to strengthening processes and prioritizing homeless veterans' engagement in the program and care at the facility. For example, leaders changed from a centralized approach (one point of entry) to a decentralized (all points of entry) approach. Previously, all referrals were directed to one point of contact. Now, when a veteran is referred to the homeless program, any HCHV staff member can accept

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

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

[61] 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.

[62] For the HCHV5 performance measure, VHA sets an escalating target each FY with the goal of reaching 100 percent by the end of the FY. VHA Homeless Program Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023. The facility reported 100 percent for FY 2024, 75 percent for FY 2022, and 74 percent for FY 2023.

the referral and begin the assessment process. Leaders said program access and enrollment increased after this change.

Program staff and leaders said they conduct outreach to identify veterans for services and receive referrals from community partners, facility staff, and city or county outreach staff. A leader reported they use the VHA-required tool (Homeless Operations, Management and Evaluation System) to track referrals and eligible veterans' progress to permanent housing.[63] In an interview, program staff said the homeless program offices are located about two miles from the facility's main site and offer veterans walk-in services, showers, meals, and primary care services. Located next door is a community program's drop-in center, which allows veterans to access resources, such as computers and games, while waiting to be seen.

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).[64]

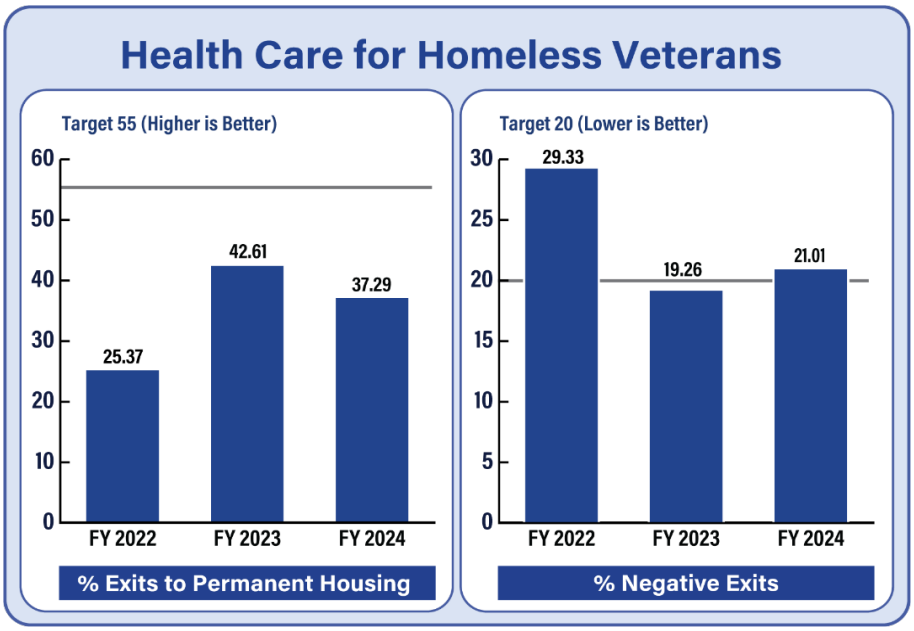

Figure 9. *HCHV program performance metrics.*
Source: VHA Homeless Performance Measures data.

[63] "Homeless Operations, Management and Evaluation System (HOMES) is VA's primary platform for collecting intake, progress and outcome information for homeless Veterans." VHA Directive 1162.08, *Health Care for Homeless Veterans Outreach Services,* February 18, 2022.

[64] 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*.

The facility did not meet the HCHV1 target for FYs 2022 through 2024. Additionally, the facility did not meet the HCHV2 target for FYs 2022 and 2024, but did meet it in FY 2023.[65] In an interview, program leaders attributed missing the targets to multiple factors: a contracted transitional housing provider that did not initially meet care management requirements but is now compliant; veterans leaving emergency shelters unexpectedly; lack of affordable housing and the area's high cost of living; and the requirement for veterans to be independent with activities of daily living, including medication management, to be placed in the shelter.

Program staff explained their coordinated efforts to network with multiple community partners to meet veterans' needs. These partners assist with emergency shelter, education and vocational training, and medical and mental health services. Program staff also coordinate with VA-funded low demand and service-intensive shelters.[66]

Program staff and leaders identified the limited transportation options outside of the Miami-Dade County area. Within Miami-Dade County, veterans can obtain a free bus pass with proof of county residency, age, or income, but many veterans are transient and do not have the required documentation. Program staff explained they rely on community partners to help transport veterans to community events and appointments.

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."[67] 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.[68]

[65] The targets remained the same for FYs 2022 and 2024. VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*, October 1, 2021; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

[66] A low demand shelter "uses a high engagement/harm reduction model to better accommodate Veterans experiencing chronic homelessness and Veterans who were unsuccessful in traditional treatment settings." Service-intensive housing "provides transitional housing and robust services that facilitate individual stabilization, increased income, and movement to permanent housing as rapidly as clinically appropriate." Department of Veterans Affairs, "US Department of Veterans Affairs (VA) Grant & Per Diem (GPD) Program Fact Sheet," July 2022, https://www.va.gov/homeless/gpd.asp.

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

[68] 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).[69] The facility did not meet the target for FYs 2022 through 2024.[70] Program staff attributed the missed targets to a lack of affordable housing and transportation, as well as some landlords' reluctance to participate in the program or rent to veterans.

To address this hesitancy, staff and leaders developed relationships with current and potential landlords. Staff said community partners helped veterans locate housing and paid for rental and utility deposits. Additionally, staff provided two examples of available housing where veterans were unwilling to reside because either the neighborhood was unsafe, or it was further from the facility and took a longer time to get there using public transportation.

In an interview with a program leader and staff, the OIG learned the program has a 53-member multidisciplinary team, with one position vacancy. The program had 1,511 vouchers as of March 1, 2025, with 1,215 veterans housed. Another 57 vouchers were assigned but the veterans did not yet have housing.

Staff mentioned an additional concern with aging veterans' ability to remain in their homes as long as possible. They provide VA resources when necessary, such as Home-Based Primary Care or home health aid, before considering alternative placements.

Staff said they use a One Team Approach in working with veterans participating in the program and found it helped lower barriers in locating housing resources.[71] The program's Coordinated Entry Specialist is the main point of contact for referrals to the homeless programs. Staff said the specialist attends community-based meetings to discuss veterans in the service area and their housing plans. For veterans who do not qualify for the program, the specialist refers them to community partners for services and resources.

[69] 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*.

[70] VHA sets targets for HMLS3 at the national level each year. For FY 2022, the HMLS3 target was 92 percent, and for FYs 2023 and 2024, the target was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*, October 1, 2021; VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

[71] In the One Team Approach, VA and community programs work together to address homelessness within a community. "VA Homeless Programs," Department of Veterans Affairs, accessed February 12, 2025, https://www.va.gov/homeless/oneteam-toolkit.asp.

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 each month (performance measure VASH3).[72] The program met the target for FY 2024.[73] In the interview, a program leader and staff attributed meeting the target to the program's Employment Specialist, who helps veterans write resumes, practice interview skills, and find full-time and seasonal work. The specialist also works with community partners that help veterans obtain professional attire.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[74] 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.[75]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[76] The facility did not meet the target for FY 2023 but did meet it for FY 2024.[77] A program leader and staff attributed meeting the target to staff consistently documenting outreach efforts in VHA's Homeless Operations, Management and Evaluation System.

In the interview with program staff, the OIG learned the program consists of three psychologists and one part-time peer support specialist. According to staff, the use of psychologists in the program is somewhat unique to the facility; they help guide treatment courts on the best way to

[72] 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*.

[73] In FY 2024, VHA set the VASH3 target at 50 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

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

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

[76] 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*.

[77] VHA set the facility VJP1 target at 50 entries for FYs 2023 and 2024. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*, October 1, 2022; VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023.

work with veterans with mental health challenges and substance use histories.[78] The program also offers educational opportunities to psychology students who run a support group for veterans starting a treatment court program.

Based on an interview and document, program staff receive referrals from facility sources, including mental health, social work, primary care and other homeless program staff; as well as a variety of external sources, such as law enforcement personnel; jail, prison, and court staff; public defenders; community partners; and veterans and their families. In addition, staff trained and encouraged federal court partners to use a database that could help them identify veterans early in the legal process.[79] Staff also said they train facility staff and community partners, such as law enforcement, legal professionals, and court staff, about the program and VA services as a way to conduct outreach. Staff explained that their outreach efforts have helped law enforcement and legal professionals better understand how to interact with veterans and connect them to VA and community resources.

Meeting Veteran Needs

Program staff said they primarily work with veterans who participate in veterans treatment courts. They conduct monthly outreach to veterans in jails and prisons, and hold individual and group sessions to inform them about available resources. When meeting with veterans, staff assess them to determine their medical, mental health, employment, housing, legal, transportation, or other needs. Staff also collaborate with legal and court staff, other VA program staff, and the veteran's family to develop a treatment plan and establish goals. The program's peer support specialist helps veterans with treatment and recovery, housing and vocational services, and serves as a point of contact for navigating VA services.

Staff explained they review veterans' electronic health records to determine their compliance with treatment and participation in VA services and report their progress during weekly veterans treatment court proceedings. The emphasis of treatment is on recovery and community integration.

Staff identified transportation as a challenge for veterans participating in a treatment court program. For example, veterans must comply with their treatment plan, which includes weekly

[78] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

[79] The Veterans Reentry Search Service is a secure website that "enables correctional and other criminal justice system entities to identify inmates or defendants who have served in the United States (U.S.) military." "Welcome to the Veterans Re-Entry Search Services, Veterans Reentry Search Service (VRSS) – Terms and Conditions of Use," Department of Veterans Affairs, accessed April 11, 2025, https://vrss.va.gov. (This website is not publicly accessible.)

court appearances, drug testing three times a week, and a variety of mental health, substance use, and case management appointments. Depending on where the veteran resides, it could take hours to get to and from the appointments on public transportation. Staff work with veterans to engage in virtual appointments to alleviate transportation needs.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to environment of care deficiencies, equipment maintenance, cleaning and medical supplies, and storage areas. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Responses). 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.

OIG Recommendations and VA Responses

Recommendation 1

The Executive Director ensures staff address environment of care deficiencies within 14 days or have an action plan, as required.

_X_ Concur

____ Nonconcur

Target date for completion: September 15, 2025

Director Comments

As of this date, September 15, 2025, top deficiencies such as damaged or missing tiles, damaged walls, improper door alignments work have been completed and with an approved action plan in place.

The Performance Logic system (PL system) is implemented and will be utilized moving forward. Environment of care deficiencies with no actions are scheduled for automatic reminder notifications which include scheduled escalation to leadership. If a deficiency request reaches its due date without resolution, weekly overdue notifications will be sent to the team responsible, including the assigned Executive Leadership Team (ELT) Member. Education has been provided by Environmental Health & Safety (EH&S) staff to the service level teams on the PL system and how to update/close or transfer deficiencies assigned to their area.

During Environment of Care (EOC) rounds, Facilities Management Service (FMS) staff perform on-the-spot repairs. Work orders are submitted for immediate follow-up for damaged walls/improper door alignment with expected completion within 14 days or if major repairs/replacement with pending National approval of contract.

Monthly EOC observations that will be reported are the number of deficiencies corrected or with an action plan/total observations of deficiencies. The Chief of EH&S will collect, analyze and report for 6 months for 100% compliance and reported to EOC Committee and Quality and Patient Safety Board.

OIG Comments

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

Recommendation 2

The Executive Director ensures staff perform preventive maintenance on medical equipment in accordance with manufacturers' recommendations.

_X_ Concur

____ Nonconcur

Target date for completion: March 2025

Director Comments

As of this date, the following actions were put in place. Monthly, the Healthcare Technology Maintenance (HTM) staff, print preventive maintenance (PM) and assign work to HTM technicians for PM completion. All new equipment is inspected and entered in Vista for it to be scheduled for routine maintenance per manufacturing instructions for use. Provided education to Service Chiefs to enter work orders when overdue PM stickers found.

An Equipment Management Program (SOP 002B-01) was developed to offer guidance to the facility and provides step-by-step processes about preventative maintenance on medical equipment to be compliant with manufacturer recommendations. The PM completion is monitored monthly. The data collected is the number of completed PM stickers / total assigned, and report monthly for 6 months for 100% compliance to EOC committee and Quality and Patient Safety Board.

OIG Comments

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

Recommendation 3

The Executive Director ensures staff evaluate the best place to store cleaning supplies, staff store them there, and leaders monitor compliance.

_X_ Concur

____ Nonconcur

Target date for completion: September 19, 2025

Director Comments

As of this date, all housekeeping closets are identified with signage outside the door. Conducted staff training in housekeeping closet locations and the proper storage of cleaning material and equipment. A post weekly Inspection supervisor Checklist was developed (9/15/2025), supervisors were trained in its use (9/19/2025) and was posted in each closet. Supervisors will conduct daily inspections of rooms and will complete the post weekly checklist. The completed

checklist will be submitted to the Chief of Environmental Management Service for review and compliance. The closets are inspected for orderly manner state and unauthorized items are not stored. The data collected is the total number of completed checklists / total number of completed supervisor observations. Observations will be conducted monthly for 6 months to achieve 100% compliance, and spot checks thereafter once goal is met. This data will be reported monthly to the Infection Control committee and assigned ELT.

OIG Comments

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

Recommendation 4

The Executive Director ensures staff remove expired medical supplies and patient food items from patient care areas.

_X_ Concur

____ Nonconcur

Target date for completion: April 14, 2025

Director Comments

As of this date, Nutrition and Food Service (NFS) par levels reviewed and adjusted bulk nourishments. Implementation of a bagging and labeling system for single serve items that do not have expiration dates individually listed. Announcement made in Tier 1 huddle reminding staff to not place items from patient trays inside of nourishment refrigerator.

Unit Pantry Inspection was implemented to include clinical staff rounding in patient care areas to verify cleanliness of refrigerator, verification of food items having the appropriate label with date, verification of no expired items, proper rotation of food items, and documentation of any corrective action needed. Quality Manager and/or Food Service Worker Lead/Trainer will conduct a weekly review of bulk nourishment delivery monitors to ensure compliance. Food Service Worker Supervisor and Lead/Trainer will conduct randomized inspections of patient nourishment areas 3 times per week. Randomized patient pantry inspections at least 4 times per month to ensure compliance with bulk delivery and storage procedures and provide immediate corrective action as indicated. The monthly data collected is the number of compliant patient nourishment rooms / Total nourishment areas inspected. The Chief of Nutrition and Food Service will review the data collected, submit contracts for repairs and report monthly for 6 months for 100% compliance to EOC committee and Quality and Patient Safety Board.

All identified expired medical supplies have been removed to include recall items. To maintain compliance, Supply Chain Management (SCM) staff increased rounding, and include routine meetings with staff in patient care areas to address hoarding, excess and/or long supply that may

result from low to no use items that could contribute to problems with expired supplies. SCM staff round daily to identify and remove expired medical supplies. Additionally, the Service has incorporated the use of amnesty bins with placement inside supply closets, whereby, clinical staff can place in the bins any expired items they identify that were not stored inside the established inventory point for disposal by SCM.

Monthly audits will be submitted with the following data: compliant supply room inspections/total number of supply rooms. The Chief of NFS and the Chief of SCM will review the data collected and report monthly for 6 months for 100% compliance to EOC committee and Quality and Patient Safety Board.

OIG Comments

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

Recommendation 5

The Executive Director ensures doors in patient care areas have signs to indicate what is stored inside.

_X_ Concur

____ Nonconcur

Target date for completion: November 30, 2025

Director Comments

Interior Design and the Sign Shop will collaborate to design and implement a standardized medical storage/supply labeling system for doors. The plan will include: (durable/compliant labels (2) applying color-coding and consistent naming conventions and (3) piloting in a selected patient care areas prior to (4) implementing a facility-wide rollout with staff training. Observations will be performed for compliance during EOC rounds and be monitored monthly for 100% compliance. The data to collect is the number of deficiencies with no corrective actions/total observations of deficiencies. The Chief of FMS will review the data collected and report monthly for 6 months for 100% compliance to the EOC committee and Quality and Patient Safety Board.

OIG Comments

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

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. 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 February 10 through 13, 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 22, 2025

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

Subj: Healthcare Facility Inspection of the Miami VA 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 Miami VA Healthcare System's Executive Director's response and concur with the findings, recommendations, and actions. VISN 8 is committed to assisting the system's leadership to close all findings expeditiously and to sustain gains.

I appreciate the efforts of the OIG in partnering with the Miami VA Healthcare System and VISN 8 to ensure the Veterans we proudly serve receive exceptional service.

For questions regarding VISN 8's response, please contact the acting VISN 8 Quality Management Officer.

(Original signed by:)

David Dunning, MPA
Interim VISN 8 Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: September 19, 2025

From: Interim Executive Director, Miami VA Healthcare System (10N8)

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

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

I have reviewed and concur with the Veterans Affairs Office of Inspector General's (VAOIG) findings and recommendations. We appreciate the partnership with VAOIG. We will work diligently to close the recommendations quickly.

For any additional information, please contact the Miami VA Healthcare System's Chief of Quality, Safety and Value Service.

(Original signed by:)

Edward C. Payton, MHS, FACHE
Interim Executive Director, Miami VA Healthcare System

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