US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Tampa Healthcare System in Florida

Healthcare Facility Inspection	25-00199-19	December 10, 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 conduct independent oversight of the Department of Veterans Affairs (VA) 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. Furthering that mission, and building on prior evaluation methods, the OIG established the Healthcare Facility Inspection cyclical review program. Healthcare Facility Inspection teams review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle to measure and assess the quality of care provided using five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The inspections incorporate VHA's high reliability organization principles to provide context for facility leaders' commitment to a culture of safety and reliability, as well as the well-being of patients and staff.

What the OIG Found

The OIG physically inspected the VA Tampa 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 reported that system shocks included a February 2024 notification of VHA's strategic hiring effort to reduce the total number of staff, Office of Personnel Management's position evaluations that delayed hiring for critical positions and reduced pay for some jobs, and several local events.[2] The Director reported the facility has continued to hire to meet existing needs, such as staffing a new hospital building. The leaders employed town halls to increase communication with staff about these changes.

The local events occurred over a span of six weeks, starting in September 2024, and included two hurricanes and the separate tragic deaths of four staff members. Executive leaders explained

[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 FY [fiscal year] [20]25 budget requires that VHA reduce cumulative staff—without sacrificing the world-class care that we are providing Veterans. To execute that plan, we must make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00),VHACO Program Office Leadership, May 31, 2024.

they used an emergency notification program and crisis response team to alert and assist staff, and additional communication methods such as text messaging and phone calls to contact veterans to offer support.

Executive leaders reported they routinely communicate with staff through huddles (short meetings to share challenges and find resolutions), rounding (visits with staff in their work locations), newsletters, and safety forums. Facility leaders described staff appreciation efforts like time off awards, bonuses, and recognition ceremonies and luncheons to improve employees' experiences at the facility.

The OIG reviewed scores from the facility's VA All Employee Survey data related to workgroup psychological safety and found scores for fiscal years (FYs) 2022 through 2024 were slightly lower than VHA averages.[3] Executive leaders reported efforts to improve performance included mentoring workgroup leaders and bringing in Veterans Integrated Service Network staff to assess work areas with lower scores.[4]

Additionally, patient advocates indicated challenges with community care for dental services and the phone system.[5] Executive leaders explained the approval process was complicated, which delayed care. They also said the phone system issues were related to a new system being installed. To address these issues, executive leaders said they established a workgroup for community care dental and facility dental leaders to meet to find solutions and a Veterans Integrated Service Network workgroup was working to resolve the phone issues.

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

[3] 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. "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.

[4] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/.

[5] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/. "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed November 1, 2024, https://www.va.gov/communitycare.

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 parking and transit options to be adequate. The facility offered a shuttle, reserved parking, and valet services for veterans who need assistance. Staff were located at reception desks at the bed tower and spinal cord injury entrances. The OIG had difficulty navigating the facility due to a lack of directional signs, and facility staff discussed a planned project to improve signs and wayfinding (the cues and tools veterans use to find their destination).

The OIG noted multiple exterior crosswalks that lacked detectable warning surfaces (features to alert visually impaired pedestrians of a hazard in the line of travel). The OIG also observed that one of the crosswalks did not have warning surfaces and spanned a road with heavy traffic. The OIG did not issue a recommendation because facility staff reported a planned project for installing detectable warning surfaces.

The OIG also found an open smoke door that did not self or automatically close, which creates a life safety risk in the event of an emergency.[6] There was a similar finding from a 2023 Joint Commission survey that identified a smoke door that did not latch.[7] Despite the possible life safety issue, facility staff acknowledged disabling the automatic closure mechanism because of a nonfunctioning identification card reader. Facility staff restored the door's automatic closure mechanism during the inspection.

Further, the OIG observed soiled utility rooms that contained biohazardous materials but lacked sinks or handwashing supplies, which increases contamination and infection risks. The OIG also found expired supplies and inconsistencies in the type and number of supplies stocked for video laryngoscopes in several clinical areas, which may result in staff lacking necessary resources in an emergency.[8] The OIG made recommendations to address these deficiencies. In response, the Director reported staff installed alcohol-based hand rub dispensers in soiled utility rooms, and the OIG closed the associated recommendation. Additionally, the Director stated staff implemented a daily monitoring process for laryngoscope supplies to ensure they are ready for immediate use (see OIG Recommendations and VA Responses).

[6] Fire doors must self-close (automatically returns to closed position) or automatically close (activated with an automatic closing device) when a fire alarm system is activated. "Occupational Safety and Health Standards, 1910.36," Occupational Safety and Health Administration, accessed June 30, 2025, https://www.osha.gov/laws-regs/regulations/1910/1910.36; "Fire Doors: Locations, Types, and Inspection Guidelines for Buildings," Certified Commercial Property Inspectors Association, accessed July 17, 2025, https://ccpia.org/fire-doors.

[7] The Joint Commission, *Final Accreditation Report: James A Haley Veterans' Hospital*, December 12, 2023.

[8] Video laryngoscopes provide a view of structures in the trachea, making it easier for medical professionals to place a tube to support patient breathing. Matthew E. Prekker et al., "Video Versus Direct Laryngoscopy for Tracheal Intubation of Critically Ill Adults," *The New England Journal of Medicine* 389, no. 5 (June 16, 2023): 418-429, https://www.nejm.org/doi/full/10.1056/NEJMoa2301601.

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 did not have the required service-level workflows, and their policy referenced an outdated VHA directive.[9] The OIG made a recommendation. In response, the Director described a facility-wide initiative to ensure each clinical service has a workflow that outlines the communication of test results to providers who order tests and patients (see OIG Recommendations and VA Responses).

The OIG reviewed a recommendation from an October 2021 inspection report that the facility's Surgical Workgroup reviews surgical deaths monthly.[10] In February 2025, the OIG examined the workgroup's meeting minutes for one recent month and found the workgroup had maintained this practice. Additionally, the OIG found that facility leaders had analyzed patient safety reporting trends and developed improvement actions to address supply shortages by enhancing communication between supply and nursing service staff.

The OIG also learned of a process improvement project in which staff use software to automatically generate test result letters to be mailed to patients when results are normal. The Deputy Chief of Staff said that staff developed the project to improve test result communication and reduce providers' administrative burden; the chief stated the project succeeded in both ways.

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 primary care delivery structure and new patient appointment wait times.[11]

The OIG found the facility had 92 teams providing primary care services across the facility's locations. There were no primary care provider vacancies, but there were vacancies among nurses and medical support assistants. To improve recruitment and retention, leaders increased pay for some positions.

The OIG also examined panel size, which is the number of patients assigned to a primary care team. The OIG noted that leaders maintained reasonable panel sizes by keeping abreast of

[9] "A service-level workflow is a written document that describes the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*, July 11, 2023, amended September 20, 2024.

[10] VA OIG, *Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida*, Report No. 21-00274-289, October 13, 2021.

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

staffing issues through reports and meetings and adjusting staffing resources as needed. Neither leaders nor staff reported that PACT Act implementation appreciably increased workload or affected operations.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs, to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the three programs had mixed success in meeting selected VHA performance measure targets. The Healthcare for Homeless Veterans Program met the target for veterans receiving intake assessments in FY 2023 but did not meet it in FYs 2022 or 2024 and did not meet the target for veterans who were discharged from the program for violating rules in FYs 2022 through 2024. The Housing and Urban Development–Veterans Affairs Supportive Housing Program met the target for percentage of housing vouchers assigned to the facility that are being used by veterans or their families for FY 2024 but had not met it in the two prior years. The Veterans Justice Program missed meeting the target for number of veterans entering the program in FY 2023 but met it in FY 2024.

Program staff identified barriers such as staff turnover, community partner staffing challenges, low affordable community housing stock, and program staff not entering veteran information into a national program database. Program coordinators reported they implemented various actions to address the obstacles, such as educating community partners on veterans' care needs and achieving a better understanding of national database reporting criteria. A coordinator also explained that housing options for veterans in the area had improved, which had led to improved program performance.

The OIG learned the Housing and Urban Development–Veterans Affairs Supportive Housing program had partnerships with multiple assisted living facilities, where veterans used housing vouchers to cover the cost of the room. In addition, the program had a specialized team including an occupational therapist who provided care to elderly and disabled veterans.

The OIG also learned that Veterans Justice Program staff participated in veterans treatment courts in each county of the facility's service area.[12] Veterans Justice Outreach coordinators worked with judges, attorneys, probation officers, and court administrators to identify and enroll

[12] "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.

veterans. In addition, coordinators conducted outreach in jails and participated in an ex-offender reentry community coalition to help veterans released from prison readjust to society.

What the OIG Recommended

The OIG made three recommendations.

1. Facility leaders ensure staff have access to sinks or hand hygiene supplies in or near soiled utility rooms that store biohazardous materials.
2. Facility leaders assess how staff monitor video laryngoscope supplies to ensure they are readily available, and staff remove supplies when they expire.
3. Facility leaders ensure staff develop service-level workflows for the communication of test results per the VHA directive.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with our inspection findings and recommendations and provided acceptable improvement plans (see OIG Recommendations and VA Responses, and appendixes C and D for the full text of the directors' comments). Based on the information provided, the OIG considers recommendation 1 closed. For the remaining open recommendations, leaders are implementing corrective actions, and the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Tampa Healthcare System
Tampa, Florida
Level 1a-High Complexity
Hillsborough County
Hospital Referral Region: Tampa

Description of Community

POPULATION

Female **2,261,670**	Male **2,138,064**
Veteran Female **36,459**	Veteran Male **280,696**

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

MEDIAN INCOME

$58,062

EDUCATION

89% Completed High School
61% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **326**

SUBSTANCE USE

22.6% Driving Deaths Involving Alcohol
21.1% Excessive Drinking
1,937 Drug Overdose Deaths

UNEMPLOYMENT RATE

4% Unemployed Rate 16+
5% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,484,340
Carpool	170,717
Work at Home	170,261
Other Means	39,909
Walk to Work	24,015
Public Transportation	18,614

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**13.5 Minutes, 8.5 Miles**
Specialty Care	**39.5 Minutes, 30.5 Miles**
Tertiary Care	**44.5 Minutes, 37.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **53,426**

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

33,832

424 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.34 Days

30-DAY READMISSION RATE

13%

SUICIDE RATE PER 100,000

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

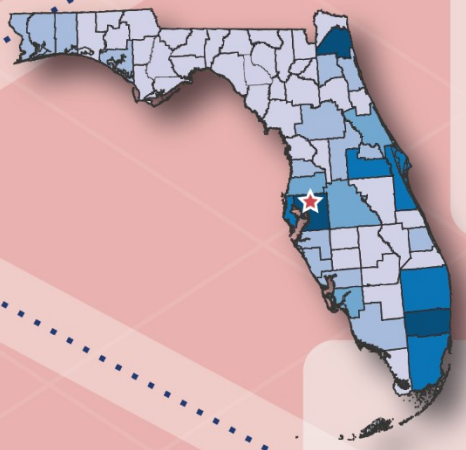
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	121K
Unique Patients VA Care	116K
Unique Patients Non-VA Care	44K

COMMUNITY CARE COSTS

Unique Patient $14,176	Outpatient Visit $321
Line Item $541	Bed Day of Care $266



STAFF RETENTION

Onboard Employees Stay <1 Yr	8.74%
Facility Total Loss Rate	9.77%
Facility Retire Rate	2.28%
Facility Quit Rate	6.73%
Facility Termination Rate	0.56%

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) 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 (VA), "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]

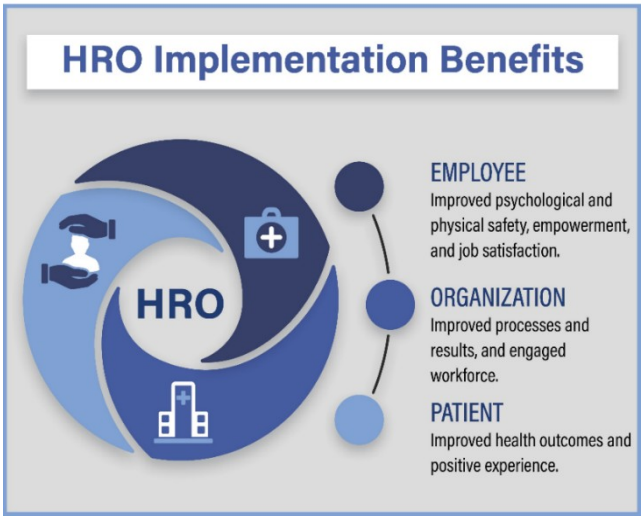


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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 VA Tampa Healthcare System (facility) provides care at locations in central Florida and includes the James A. Haley Veterans' Hospital, which originally opened in 1972.[13] The facility's budget was approximately $2 billion in fiscal year (FY) 2024.[14] The Associate Director, Patient Care/Nursing Services stated the facility had 512 operating beds (193 acute care hospital, 40 inpatient mental health, 55 community living center, 166 spinal cord injury, and 58 domiciliary beds).[15] Leaders said the facility had opened five new clinics since 2022, four of which included primary care services, as well as a new bed tower (a multi-story building for inpatient care) at the main site.[16] The facility also had 23 accredited rehabilitation programs, including polytrauma programs.[17]

At the time of the OIG's inspection in February 2025, the facility's executive leaders consisted of the Director; Deputy Director; Associate Director; Chief of Staff; Associate Director, Patient Care/Nursing Services; and Acting Assistant Director. The Chief of Quality Management reported that the newest member of the leadership team, the Chief of Staff, was assigned in August 2024, and the most tenured, the Deputy Director, started in January 2016. The Acting Assistant Director was covering the position while the permanent Assistant Director was temporarily assigned to another facility.

[13] "About Us," Department of Veterans Affairs, accessed January 22, 2025, https://www.va.gov/tampa-health-care/about-us/.

[14] This amount includes approximately $455 million allocated for care provided in the community. "VA provides care to Veterans through community providers when VA cannot provide the care needed. Community care is based on specific eligibility requirements, availability of VA care, and the needs and circumstances of individual Veterans." "Community Care," Department of Veterans Affairs, accessed November 1, 2024, https://www.va.gov/communitycare.

[15] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/Geriatrics/VA_CLC.asp. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed November 19, 2024, https://www.va.gov/homeless/dchv.asp.

[16] The five new clinics are in Lakeland, New Port Richey, Tampa, Temple Terrace, and Zephyrhills. All clinics except Temple Terrace include primary care services. The new bed tower opened in January 2023. Chuck Walker, "USACE and VA Celebrate Tampa Bed Tower Grand Opening," Army Corps of Engineers, January 25, 2023, https://www.sam.usace.army.mil/usace-and-va-celebrate-tampa-bed-tower-grand-opening/.

[17] Polytrauma occurs "when TBI [traumatic brain injury] is associated with a significant secondary injury (amputation, burn, fractures) or with mental health conditions (post-traumatic stress, depression, anxiety, substance use)." "Polytrauma/TBI System of Care," Department of Veterans Affairs, accessed February 18, 2025, https://www.polytrauma.va.gov/.

A 2018 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."[18] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[19] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[20]

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.[21] 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.[22]

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. Executive leaders reported a system shock in February 2024, when Veterans Integrated Service Network (VISN) leaders notified them of a VHA strategic hiring effort to reduce the

[18] 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.

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

[20] 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.

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

[22] 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*.

total number of staff by FY 2025.[23] The Director explained this effort resulted in leaders reprioritizing hiring to meet the facility's most critical existing needs, for example, staffing the new bed tower. Additionally, the Director stated that staff at the Office of Personnel Management were evaluating some job descriptions, and during that time, leaders could not hire for those positions. The Director said this delayed leaders hiring staff in critical positions such as police. The Director also explained the Office of Personnel Management's evaluations reduced pay ranges for some positions, such as housekeeping staff, purchasing agents, and an industrial hygienist.[24]

Executive leaders said they communicated information related to the strategic hiring effort and reduced pay ranges during town hall meetings and provided staff opportunities to ask questions and feel heard. During the meetings, staff expressed that reduced pay and hiring delays negatively affected their morale and made positions less attractive to candidates. The Director also stated staff recently said they felt undervalued as federal workers. Therefore, executive leaders held recognition ceremonies to highlight staff and the value they bring to the facility, in addition to normal communication and activities like the town halls.

Additionally, executive leaders described a series of local events within a six-week time frame in fall 2024 as shocks to the system. The events included two hurricanes and the traumatic deaths of four off-duty staff members, which were unrelated to the hurricanes or to each other. In response, leaders reported they used the Employee Assistance Program and the facility's Critical Incident Response Team to provide mental health support for staff.[25] Executive leaders also said they used a VA mass warning and notification system during the hurricanes to account for staff safety and communicated with them through multiple daily email messages. Further, the leaders also established a text messaging system to contact patients and called vulnerable patients directly (for instance, those with spinal cord injuries or plug-in oxygen devices) to coordinate any needed

[23] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. "Veterans Integrated Service Networks," Department of Veterans Affairs, accessed February 3, 2025, https://department.va.gov/integrated-service-networks/. "The FY [20]25 budget requires that VHA reduce cumulative staff—without sacrificing the world-class care that we are providing Veterans. To execute that plan, we must make strategic, Veteran-centric decisions about which positions we should be hiring, filling, or managing through attrition." Under Secretary for Health (USH) (10), "VHA FY 2024 Hiring and Attrition Approach," memorandum to Veterans Integrated Service Network Directors (10N1-10N23) Medical Center Directors (00), VHACO Program Office Leadership, May 31, 2024.

[24] Industrial hygienists evaluate workplace dangers and implement appropriate measures to control or remove them. Occupational Safety and Health Administration, Office of Training and Education, *Industrial Hygiene,* accessed March 18, 2025, https://www.osha.gov/sites/default/files/training-library_industrial_hygiene.pdf.

[25] The Employee Assistance program is "a voluntary and confidential program that helps employees work through various life challenges that may adversely affect job performance, health, and personal well-being. Services can include assessments, counseling, and referrals for additional services." Department of Veterans Affairs, *Clinical Strong Practice (CSP) Employee Assistance Program (EAP)*, June 30, 2020. The Critical Incident Response Team is comprised of psychologists, chaplains, and counselors who support staff through processing traumatic incidents. "The Critical Incident Response Team—How Team Tampa Stays Mission Ready," Department of Veterans Affairs. On February 13, 2025, VA's website contained this information (it has since been removed from their website).

transfers to the facility during the hurricanes. The Director reported using these shocks as learning opportunities. For example, leaders began to apply color-coding tags on staff's badges during hurricanes to improve the headcount.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[26] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[27] 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."[28]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[29] The OIG found survey scores related to senior leader communication and information sharing had little change from FYs 2022 through 2024, but remained better than VHA averages. Executive leaders shared they communicate with staff through town hall meetings, newsletters, and rounding (visits to staff in their work areas). The Deputy Director stated executive leaders also hold huddles (short meetings) so staff can share problems and identify solutions. The Associate Director, Patient Care/Nursing Services reported meeting with staff monthly to listen to their concerns and recommendations.

Additionally, executive leaders explained they embedded HRO principles (leadership commitment, safety culture, and continuous improvement) into the facility's core values; encouraged staff to report patient safety events, tracked patient safety event reports, trained new staff on performance improvement, and held quarterly safety forums. Facility staff provided an example of the January 2025 safety forum, which showcased process improvements that directly resulted from staff reporting patient safety events.

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

[27] 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*.

[28] 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.

[29] 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.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[30] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[31] 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.

The OIG found survey scores related to best places to work improved from FYs 2022 through 2024 and exceeded VHA averages. Scores for no fear of reprisal changed little from FYs 2022 through 2024 and were better than VHA averages in two of the last three years. The Director described focusing on employee appreciation efforts, such as granting time off to those who worked during the hurricanes and giving bonuses the last pay period of 2024. The Chief of Quality Management explained that facility leaders also offered tai chi and yoga and an employee celebration luncheon.

The OIG found survey scores related to workgroup psychological safety were slightly lower than VHA averages for FYs 2022 through 2024. Executive leaders reported they mentored facility leaders with lower survey scores on strategies to improve employees' sense of safety. Also, executive leaders explained they requested and received VISN assistance to conduct facility workplace assessments, which included employee surveys, so they could target improvement efforts.

Veteran Experience

VHA evaluates veterans' experiences indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[32] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

Patient advocate responses to an OIG questionnaire highlighted veterans' most common complaints: delays in receiving community care dental services and difficulty using the facility's phone system. The Chief of Staff explained how the coordination of care is complicated by the consult approval process, which delays dental services. The process includes an initial consult

[30] "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.

[31] 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.

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

with the community care dental provider for a treatment plan, followed by VA staff's review of the plan for approval, which could go back and forth between the community provider and VA staff several times; facility community care staff then schedule the veteran's appointment with the community provider. The Chief of Staff reported establishing a workgroup for community dental providers and facility dental leaders to discuss coordination barriers and find solutions.

The Director discussed the phone system problems. Leaders had a new phone system installed within the last year, but staff transferred some calls to extensions that were not in use. Executive leaders responded by having staff speak directly to the call's recipient before transferring the caller. Other VISN facilities were also experiencing call routing issues, and the Director said a VISN workgroup was actively working on the problem.

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.[33] 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 4. *Facility photo.*
Source: "VA Tampa Health Care," Department of Veterans Affairs, accessed January 22, 2025, https://www.va.gov/tampa-health-care/locations/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[34] 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

[33] VHA Directive 1608(1).

[34] 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.

evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[35]

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.

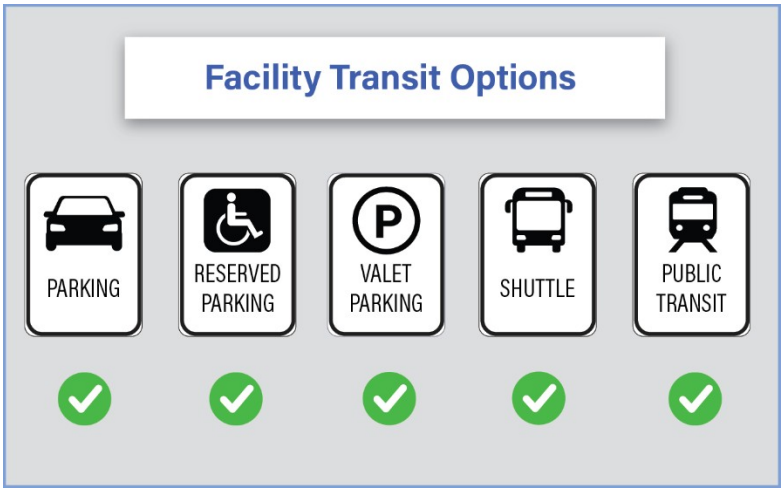


Figure 5. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and questionnaire responses.

The OIG used a commercial navigation application to travel to the facility and found the instructions easy to follow. The OIG also noted the facility has adequate parking and transit options for veterans to get around the large, multi-structure site. The facility offers a shuttle between the parking garage and patient care areas and valet parking for disabled veterans who need assistance.

On inspection of the exterior grounds, the OIG observed multiple crosswalks that lacked detectable warning surfaces (tactile features to alert visually impaired pedestrians of a hazard in the line of travel), which could create a safety issue. The OIG was concerned about one crosswalk in particular that spanned a roadway with heavy traffic and did not have warning surfaces on either side of the crossing. In one parking area, the OIG observed faded pavement symbols that mark the parking spaces accessible for those with disabilities, which makes it difficult for veterans to know who is permitted to park there. The OIG did not issue a recommendation because the Chief of Facilities Management Service said leaders planned to have detectable warning surfaces installed and parking areas repainted in calendar year 2025.

[35] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*, May 2023; Department of Veterans Affairs, *VA Barrier Free Design Standard*, January 1, 2017, revised November 1, 2022; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook,* January 2024; Access Board, *Architectural Barriers Act (ABA) Standards,* 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2023.

Main Entrance

Figure 6. *Bed tower 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.[36]

The OIG observed the entrances at the bed tower (main entrance) and spinal cord injury area. Both entrances have reception desks with staff who greet veterans and aid with navigation. The bed tower entrance has wheelchairs available for use, as well as a coffee shop and seating areas.

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.[37]

The OIG encountered difficulties navigating the facility using posted signs. For example, the OIG did not see signs in the bed tower directing veterans to locations. Additionally, the OIG observed signs indicating masks were required in certain clinical areas (such as exam rooms), though facility staff stated masks were no longer required. The OIG did not issue a recommendation because the Chief of Facilities Management Service said leaders

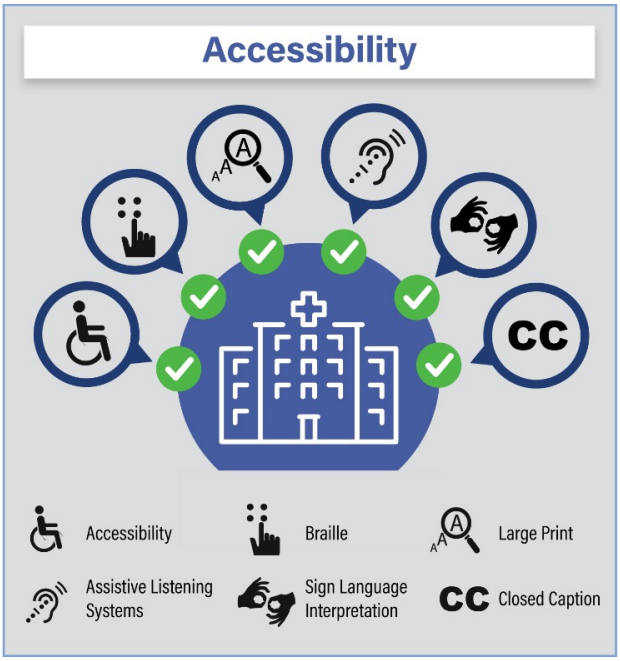


Figure 7. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG interviews and analysis of documents.

[36] VHA Directive 1850.05, *Interior Design Program*, January 11, 2023; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

[37] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

were in the design phase of a project to improve signs and wayfinding (the cues and tools veterans use to find their destination).[38]

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[39] The OIG observed large print and braille on signs. The facility offers sign language interpretation and desk staff explained they communicate with individuals with hearing impairments through writing.

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.[40]

The OIG noted the facility had two toxic exposure screening navigators. Despite having additional duties, both reported adequate resources to carry out their navigator responsibilities. The OIG reviewed toxic exposure screening data and found staff had screened over 100,000 veterans, with only 30 unresolved (started but not completed) screenings, all less than 30 days old.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[41]

The OIG analyzed facility data such as multiple work orders reporting the same issue, environment of care inspection findings, and reported patient advocate concerns. The OIG also examined recommendations from prior OIG inspections to identify areas with recurring issues and barriers to addressing these issues.

The OIG reviewed a 2023 Joint Commission survey finding that a smoke door (self-closing or automatic-closing) designed to act as a barrier to the passage of smoke in the event of a fire did

[38] VHA Directive 1850.05; Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*; Department of Veterans Affairs, *VA Signage PG-18-10, Design Manual*.

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

[40] 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.

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

not latch.[42] Similarly, the OIG observed an open smoke door that did not automatically close, which could create a life safety risk.[43] The OIG noted a work order for this door dated April 2024, but did not find documentation showing staff had fixed it.

The Chief of Facilities Management Service explained the identification card reader for the door was not working, so engineering staff disabled the door's automatic closure mechanism to allow staff to access the area. The Safety Officer confirmed staff had taken no steps to reduce life safety risks while the smoke door was disabled, such as creating a temporary barrier and routing other staff away from the door. During the inspection, staff enabled the door to close automatically, so the OIG did not issue a recommendation.

General Inspection

Maintaining a safe healthcare environment is an integral component to VHA providing quality care and minimizing patient harm. The OIG's physical inspection of areas in the inpatient, outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected multiple clinical areas and identified several problems affecting the facility's safety and functionality.[44] The OIG observed some soiled utility rooms that contained biohazardous materials and lacked available hand hygiene supplies. One room did not have a handwashing sink, soap, or hand sanitizer, and in another, the sink was blocked by equipment. The OIG recommended facility leaders ensure staff had access to sinks or hand hygiene supplies in or near soiled utility rooms that store biohazardous materials. In response, the Director explained staff installed alcohol-based hand rub dispensers in soiled utility rooms, and the OIG closed the recommendation (see OIG Recommendations and VA Responses).

[42] Fire doors must self-close (automatically returns to closed position) or automatically close (activated with an automatic closing device) when a fire alarm system is activated. "Occupational Safety and Health Standards, 1910.36," Occupational Safety and Health Administration, accessed June 30, 2025, https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.36; "Fire Doors: Locations, Types, and Inspection Guidelines for Buildings," Certified Commercial Property Inspectors Association, accessed July 17, 2025, https://ccpia.org/fire-doors; The Joint Commission, *Final Accreditation Report: James A Haley Veterans' Hospital*, December 12, 2023.

[43] The Joint Commission expects the facility to have "a written interim life safety measures (ISLM) policy that covers situations when Life Safety Code deficiencies cannot be immediately corrected." The standard includes criteria for evaluating when and to what extent the hospital implements life safety measures to compensate for increased risk. The Joint Commission, *Standards Manual,* E-dition, LS.01.02.01, July 1, 2025.

[44] The Joint Commission expectation is that a hospital "maintains a safe, functional environment." The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, August 1, 2024.

Additionally, in several patient care areas, the OIG observed inconsistencies in the type or number of supplies stocked for video laryngoscopes, and some supplies were expired.[45] These inconsistencies could result in staff lacking necessary supplies in an emergency. The Assistant Chief of Respiratory Therapy explained that respiratory therapy staff documented whether supplies were present and intact on a checklist each night, but they were not responsible for checking supplies in all clinical areas.[46]

In the Medical Intensive Care Unit, the OIG noted supplies for two video laryngoscopes were missing, although respiratory therapy staff documented that all supplies were present. Additionally, the OIG found some supplies were expired or opened. In the Emergency Department, the Nurse Manager stated the physicians were responsible for managing the supplies, but the OIG found there was no supply checklist, suggesting a lack of a standard process within the organization. The OIG recommended facility leaders assess how staff monitor video laryngoscope supplies to ensure they are readily available, and staff remove supplies when they expire. In response to the recommendation, the Director reported staff implemented a daily monitoring process for laryngoscope supplies so they are ready for immediate use (see OIG Recommendations and VA Responses).

When asked about infrastructure challenges, facility staff said they identified safety issues during the first annual elevator test for the bed tower building. The staff explained that the Army Corps of Engineers managed the building's construction, and before the hand off from the construction contractor to facility staff, staff expressed concerns the contractor had not adequately addressed all items. They reported believing the deficient elevators resulted from a lack of oversight by the engineers who signed off on the project. Facility leaders acted promptly once aware of the deficiencies and had repairs made to ensure safe operations of the elevators. The OIG referred this concern to the OIG hotline management team.

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.

[45] Video laryngoscopes provide a view of structures in the trachea, making it easier for medical professionals to place a tube to support patient breathing. Matthew E. Prekker et al., "Video Versus Direct Laryngoscopy for Tracheal Intubation of Critically Ill Adults," *The New England Journal of Medicine* 389, no. 5 (June 16, 2023): 418-429, https://www.nejm.org/doi/full/10.1056/NEJMoa2301601.

[46] Respiratory staff were not responsible for checking video laryngoscope supplies in the Emergency Department, operating rooms, or Post Anesthesia Care Unit.

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.[47] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[48] 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.

VHA requires facility staff to develop a local policy and service-level workflows that outline the process for communicating test results.[49] The OIG found the facility policy referenced an outdated VHA directive. The Chief of Quality Management indicated staff were updating the policy. The OIG also identified that the facility only had service-level workflows for the Pathology and Laboratory Service and Radiology Service. The Chief of Quality Management acknowledged the missing workflows, adding that leaders had overlooked their development because they believed the requirement was unclear.[50] The OIG recommended facility leaders ensure staff develop service-level workflows for the communication of test results per the VHA directive. In response, the director described a facility-wide initiative to ensure each clinical service has a workflow that outlines the communication of test results to providers who order tests and patients (see OIG Recommendations and VA Responses).

The OIG reviewed test result communication data from FY 2024 and found staff communicated abnormal results to patients within 7 days 85 percent of the time, and within 30 days 92 percent of the time.[51] In an interview, the Chief of Quality Management told the OIG the facility's goal is 95 percent or higher for both metrics, and the Systems Redesign Coordinator described a process improvement project to increase these percentages by using an automated mail notification system, discussed later in the domain.

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

[48] 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.

[49] "A service-level workflow is a written document that describes the processes for communicating test results for each clinic, service, department, unit, or other point of service where tests are ordered." VHA Directive 1088(1).

[50] VHA Directive 1088(1).

[51] CTR [Communication of Test Results] 24 is a metric that identifies "the percent of outpatient tests with Abnormal results that require action were communicated to [a] patient" within seven days "from the time the test result is available." CTR 25 is a metric that identifies "the percent of outpatient Abnormal Test Results that require action that were communicated to [a] patient within 30 days from the time the test result is available." "Electronic Technical Manual (eTM) Measure Library," VA Office of Information and Technology, accessed December 18, 2024, http://pm.rtp.med.va.gov/ReportServer/Pages/ReportViewer.aspx. (This website is not publicly accessible.)

The Patient Safety Manager shared that staff in clinical services throughout the facility also report data on critical test result communication to Quality Management staff. Quality Management staff then track and trend the data and present them at quarterly Quality Patient Safety Board meetings. Further, the Associate Chief of Staff for Ambulatory Care explained that providers' peers and supervisors review a sample of electronic health records for timeliness of test result communication as part of providers' annual performance evaluations.

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.[52] 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 recommendations from its prior comprehensive healthcare inspection reports and noted all recommendations were closed (staff completed the action plans).[53] The OIG interviewed the Deputy Chief of Staff to determine if the Surgical Workgroup sustained improvement actions for a recommendation to review surgical deaths each month.[54] The deputy stated the workgroup has continued to meet since receiving the recommendation and reviews all surgical deaths that occurred in the prior month. The OIG also reviewed the workgroup's meeting minutes from a randomly selected recent month and found it had maintained this practice.

When asked in an OIG interview how the facility monitors action plans for sustainment, the Patient Safety Manager provided an example of a software system staff use to monitor patient safety data trends and sustained improvements from prior completed root cause analyses.[55] The Patient Safety Manager elaborated that staff use these trends to shape future improvement projects.

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

[53] VA OIG, *Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida*, Report No. 23-00010-84, February 22, 2024; VA OIG, *Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida*, Report No. 21-00274-289, October 13, 2021.

[54] VA OIG, *Comprehensive Healthcare Inspection of the James A. Haley Veterans' Hospital in Tampa, Florida*.

[55] A root cause analysis is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

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.[56] 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.[57] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

In the interview, the Patient Safety Manager said the facility's patient safety culture encourages staff to robustly use the patient safety event reporting system to identify and prevent potential patient harm. The manager elaborated that the more frequently staff report patient safety issues at the point of care, the better they can identify areas for improvement. The Chief of Staff and the Associate Director, Patient Care/Nursing Services stated they generally become aware of patient safety concerns immediately, through the reporting system, morning huddles, Nursing Officer of the Day facility activity reports, and direct phone calls and texts from staff.[58] A Risk Manager described educating staff during quarterly safety forums to improve safety by reporting concerns.

Staff and leaders elaborated on their efforts to implement process improvement projects in response to patient safety trends. For example, the Chief Medical Informatics Officer explained that staff implemented an automated mail notification system, referred to as Auto-mail, using software and the electronic health record to generate letters to a contracted vendor, who prepares and mails normal test results to patients. The Deputy Chief of Staff told the OIG they developed the Auto-mail notification process because facility leaders wanted to improve normal test results communication and reduce the administrative burden on providers. The Chief of Staff commented that the Auto-mail process has been successful in both areas.

In January 2025, facility leaders noted an upward trend in the number of patient safety reports staff entered because of supply shortages. To address the trend, leaders developed an action plan to improve communication between nurses and supply staff. The Chief of Quality Management stated supply managers met with nursing leaders to discuss current and anticipated supply shortages and offer available substitutions. Facility staff reported this project enabled nursing leaders to anticipate supply challenges, provide input on substitutions, and ensure staff receive information about changes.

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

[57] VHA Directive 1050.01(1).

[58] Staff use the Joint Patient Safety Reporting system to report patient safety events. VHA National Center for Patient Safety, *JPSR [Joint Patient Safety Reporting] Guidebook*, December 2023.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[59] 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.[60] 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.[61] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

During interviews, the Associate Chief of Staff, Primary Care explained the facility provides primary care services through 92 teams. Primary care leaders reported the facility did not have provider vacancies but did have the following vacancies: seven registered nurses, four licensed practical nurses, and seven medical support assistants. The associate chief credited the facility's success in maintaining full primary care provider staffing to its large residency program and a dedicated physician recruiter.[62] The leader explained the residency program is structured to integrate resident physicians with primary care teams, which improves recruitment efforts.

For nursing positions, the Chief Nurse, Ambulatory Care stated that in FY 2024, increased pay for primary care licensed practical nurses had helped fill positions. The Chief, Health Administration Services reported leaders also approved a salary increase for medical support assistants in FY 2024, which improved retention and recruitment. Additionally, the Associate Chief of Staff believed retention and recruitment improved after leaders upgraded primary care buildings to be more spacious and welcoming.

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[59] 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.

[60] 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).

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

[62] "The Medical and Dental Education Program brings together academic institutions and U.S. Department of Veterans Affairs (VA) medical centers (VAMCs) to provide Graduate Medical Education (GME). Each year, the program provides clinical experiences to over 51,000 physician residents, 29,000 medical students, and 1,000 dental residents and students." "Medical and Dental Education," Department of Veterans Affairs, accessed August 18, 2025, https://department.va.gov/academic-affiliations/medical-and-dental/.

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.[63] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[64]

The OIG found the facility's primary care panels averaged 98 percent of VHA's expected size at the end of FY 2024. During an interview, the OIG learned that primary care leaders monitored staffing through internal reports and primary care leader meetings to strategically align resources to ensure reasonable panel sizes. Primary care staff agreed their panel sizes and staffing levels allowed them to properly care for patients.[65] However, a provider noted that although the clinical workload was manageable, numerous administrative duties limited the time spent on direct patient care.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[66] 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.

Although currently there were few primary care staffing vacancies, team members reported the strategic hiring effort in FY 2024, which eliminated some positions, had affected workload and resulted in staff burnout. To address the staffing shortages, both team members and leaders said they used float staff (staff who are not assigned to a team and cover vacant positions) to assist with workload. The Associate Chief of Staff further explained that float providers helped to reduce burnout and maintain quality patient care. The Chief Nurse, Ambulatory Care also described having float nurses, including some who work at two or three different sites, to ensure adequate coverage.

The PACT Act and Primary Care

The OIG reviewed the facility's veteran enrollment following PACT Act implementation and determined whether it had an impact on primary care delivery. The OIG found average appointment wait times were less than 4 days for established patients and less than 20 days for new patients in FYs 2023 and 2024. Documentation showed veteran enrollment increased

[63] "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).

[64] VHA Directive 1406(2).

[65] Primary staff included a primary care provider, registered nurse, licensed practical nurse, and medical support assistant.

[66] VHA Handbook 1101.10(2).

1.8 percent from August 2023 through July 2024. Primary care team members and leaders did not feel the PACT Act and associated toxic exposure screenings caused a noticeable increase in their workload or affected team functioning.

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.[67]

A veteran who had fallen behind on rent payments went to the HCHV program's walk-in clinic. HCHV staff helped the veteran access transitional housing, medical care, and VA benefits. They also worked with community partners to help the veteran with rental deposits, a rent subsidy, and household furniture. The veteran found new housing within two months.

Figure 8. *Success story for veteran engagement. Source: OIG analysis of a questionnaire response.*

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).[68] 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."[69]

The program met the target in FY 2023 but did not meet it in FYs 2022 or 2024. The HCHV Section Chief told the OIG that staffing transitions were a barrier in FY 2024, when the program lost three staff members, and performance decreased during new staff's hiring and orientation.

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

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

[69] Local Department of Housing and Urban Development offices administer the annual point-in-time count. The count includes those living in shelters and transitional housing each year. Every other year, the count also includes unsheltered individuals. "VA Homeless Programs, Point-in-Time (PIT) Count," Department of Veterans Affairs, accessed May 30, 2023, https://www.va.gov/homeless/pit_count.

The HCHV Outreach Supervisor stated program staff use a list of homeless veterans in the community to conduct targeted outreach.[70] The supervisor also reported that staff, as well as the facility Director, participated in point-in-time counts, and they also identify veterans for program enrollment through their walk-in clinic for homeless veterans, their call center for homeless programs, and the National Call Center for Homeless Veterans.[71] In January 2025, the supervisor stated staff served 59 veterans in the walk-in clinic and received 224 calls from the National Call Center for Homeless Veterans. The HCHV Section Chief anticipated the program would meet the FY 2025 target for engaging homeless veterans.

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).[72]

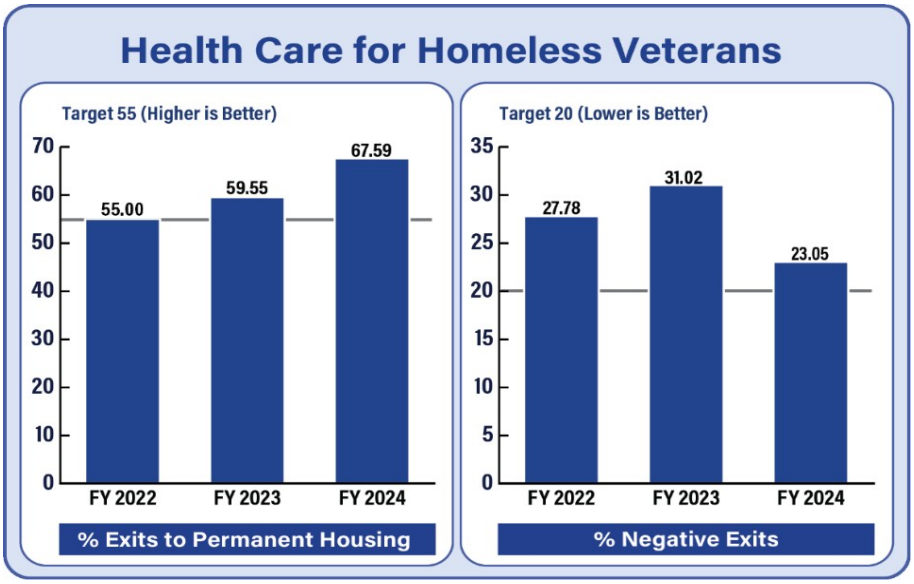

Figure 9. *HCHV program performance metrics.*
Source: VHA Homeless Performance Measures data.

[70] When VA medical centers or community partners become aware of veterans experiencing homelessness, staff add them to the community's veteran by-name list. "How Coordinated Entry Serves Veterans Experiencing or At Risk of Homelessness," Department of Veterans Affairs, accessed March 27, 2025, https://www.va.gov/coordinated-entry.

[71] The HCHV Section Chief told the OIG the program's call center for homeless programs was available 8:00 a.m. to 4:00 p.m., Monday through Friday, and staff return calls within 24 hours for messages left after hours. The VA National Call Center for Homeless Veterans has counselors available 24 hours a day, seven days a week for veterans who are homeless or at risk of homelessness. "National Call Center for Homeless Veterans," Department of Veterans Affairs, VA Homeless Programs, accessed February 24, 2025, https://www.va.gov/NationalCallCenter.asp.

[72] 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*.

For FYs 2022 through 2024, the program met HCHV1 targets but did not meet HCHV2 targets. The HCHV Outreach Supervisor described one reason for negative exits as staff turnover at transitional shelters and the need to repeatedly train new staff. To mitigate this, HCHV staff educated new shelter staff on veterans' care needs. The HCHV Section Chief identified another barrier as turnover in HCHV staff who worked with the shelters; however, during FY 2024, leaders upgraded the positions to a higher pay level to promote retention and reported this had been effective.

The section chief reported shelters had some beds designated for female veterans but limited resources for families. Therefore, when staff work with homeless families, they contact community partners or use emergency funds for short term hotel stays until they find an appropriate housing solution. In addition, the program outreach supervisor described a need for shelters that accommodate veterans with complex medical needs who do not require hospitalization but need support to live independently (such as administering medications, cooking, or light housekeeping).

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."[73] 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.[74]

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).[75] The program did not meet the target in FYs 2022 and 2023 but did meet it in FY 2024. A Housing and Urban Development–Veterans Affairs Supportive Housing Program Supervisor said that when an influx of people moved to the local area, rental costs increased, and housing

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

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

[75] 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*.

availability decreased. However, housing options have since improved, which contributed to them meeting the target in FY 2024.

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).[76] The program met the target from FY 2022 to FY 2024. A Housing and Urban Development–Veterans Affairs Supportive Housing Program Supervisor reported each team has an Employment Specialist who works to find veterans stable employment or education opportunities that will lead to a career path. The specialists also work with the facility's vocational rehabilitation program to help veterans find jobs.

A program supervisor described a partnership with two public housing authorities and 13 assisted living facilities that enabled veterans to use housing vouchers for rooms.[77] The supervisor noted they have a specialized team for older and disabled veterans that includes an occupational therapist, who provides medical assessments and can schedule consults for psychological evaluations. Another program supervisor added that the occupational therapist can also order mobility aids such as walkers.

One supervisor shared that staff intervene early when veterans are at risk of losing their housing by meeting with them to develop a plan for stable housing. If veterans are unable to maintain their housing despite interventions, staff work with them to create a transition plan that includes temporary shelter and community resources.

A Housing and Urban Development–Veterans Affairs Supportive Housing Program Supervisor told the OIG about a veteran who was a single parent with a young child and temporarily staying at friends' homes or sleeping in a car. With help from program staff, the veteran acquired stable housing, returned to school, and over time became a homeowner. After completing an educational program, the veteran got a job in the social services field.

Figure 10. *Success story for outreach and veteran engagement. Source: OIG analysis of a questionnaire response.*

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[78] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law

[76] 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*.

[77] "Assisted living is for people who need help with daily care, but not as much help as a nursing home provides.…Typically, a few levels of care are offered, and residents pay more if they need extra services or special care." "Long-Term Care Facilities: Assisted Living, Nursing Homes, and Other Residential Care," National Institute on Aging, accessed February 20, 2025, https://www.nia.nih.gov/health/assisted-living-and-nursing-homes.

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

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.[79]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[80] The program missed the target in FY 2023 but met it in FY 2024. In an interview, the Section Chief, Homeless Veterans Program told the OIG that in FY 2023, the metric was new, and leaders were still determining program eligibility requirements. A Veterans Justice Outreach coordinator acknowledged staff were uncertain whether some veterans were eligible and therefore did not enter them into the national database. They gained a better understanding of the criteria and a renewed focus on updating the database, which helped to meet the target in FY 2024. The Veterans Justice Outreach coordinators explained that jail staff often identified veterans for program enrollment.

A Veterans Justice Outreach coordinator said they provided outreach at a jail with sections designated for veterans, where inmates are required to engage in life skills training and other educational programs. Veterans Justice Program coordinators also participated in veterans treatment courts in each county in the facility's service area.[81] Coordinators reported they meet regularly with judges, attorneys, probation officers, and other court personnel to identify veterans for program enrollment. Additionally, one coordinator stated they provide case management for the duration of veterans' participation in the court program, and work with the courts to facilitate treatment referrals for issues such as substance use or anger management.

A program coordinator discussed a jailed veteran with a history of homelessness and drug use who was a Purple Heart recipient. After entering a veterans treatment court program, the veteran also enrolled in transitional housing with the help of Veterans Justice Program staff. After completing the treatment court requirement, the veteran became active in a mental health recovery program with treatment by a facility provider. The veteran subsequently reestablished relationships with family members.

Figure 11. *Success story for enrollment in Veterans Justice Program.*
Source: OIG analysis of documents.

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

[80] 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*.

[81] "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.

Meeting Veteran Needs

A Veterans Justice Outreach coordinator explained that over the past two years, program coordinators have participated in a few cases for veterans in federal court. The coordinator described working with six veterans currently, and added the numbers appear to be growing rapidly as federal court staff become more familiar with the program. The facility Director told the OIG staff were formally expanding their role of working with veterans treatment court programs within federal courts in the service area.

To support veterans released from prison in their transition back into society, one program coordinator participates in an ex-offender reentry coalition comprised of community partners that work together and share resource information. Additionally, program staff partner with a local legal service to offer a free legal clinic to help veterans with non-criminal issues. The clinics are held at the facility's medical center and at their VA clinic in Pasco County.

In July 2023, the facility formed a deflection team as part of a community-based VA effort to divert veterans to mental health services so they can avoid involvement with the criminal justice system. The facility's deflection team, which includes a Veterans Justice Outreach coordinator, VA police, and mental health services staff, works with county sheriff offices' behavioral health units.

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 hand hygiene, video laryngoscope supplies, and test result communication. Leaders have started to implement corrective actions, and completed corrective actions for one recommendation, which the OIG closed (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

Facility leaders ensure staff have access to sinks or hand hygiene supplies in or near soiled utility rooms that store biohazardous materials.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

Recommend closure of this action item. The Assistant Chief of Environment Management Service and Quality Management Specialist conducted an inspection of all soiled utility rooms in the hospital to confirm if hand hygiene is available. Inspection ensured the presence of a sink and soap or alcohol-based hand rub (ABHR) dispenser (if neither is present request ABHR dispenser installation). A total of 39 rooms were inspected and only seven rooms required the installation of an ABHR.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 2

Facility leaders assess how staff monitor video laryngoscope supplies to ensure they are readily available, and staff remove supplies when they expire.

_X_ Concur

____ Nonconcur

Target date for completion: February 27, 2026

Director Comments

The identified areas that utilized the video laryngoscope are being inspected daily to confirm all scopes and supplies are ready for immediate use. The monitoring of the inspections will continue until benchmark of 90% is achieved for six consecutive months. The results of the compliance report are being reported to the ICU Committee.

OIG Comments

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

Recommendation 3

Facility leaders ensure staff develop service-level workflows for the communication of test results per the VHA directive.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

James A. Haley Veterans' Hospital and Clinics will implement a facility-wide initiative to ensure compliance with VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023. The Chief of Staff is responsible for leading this action item and will ensure that each clinical service documents their service-level workflow policy that clearly outlines the receipt of test results from diagnostic services to the ordering provider or designee and the communication of test results to the veteran within the established timelines. To ensure accountability and standardization across the organization, 100% of clinical services will be audited to confirm the establishment of a policy that defines the workflow for receiving and communicating test results. Compliance data will be reported monthly to the Medical Executive Committee (MEC) until full (100%) compliance is achieved. The target date for full implementation and compliance is June 2026.

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: October 15, 2025

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

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

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

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

1. I appreciate the partnership with VAOIG in ensuring the Veterans we proudly service receive exceptional healthcare services. I have reviewed the VAOIG's draft report and concur with the findings and recommendations as well as the Acting Medical Center Director's actions.
2. VISN 8 is committed to assisting the Tampa VA Healthcare System's leadership in completing all actions timely. For questions, please contact the VISN 8 Quality Management Officer.

(Original signed by:)

David Dunning, MPA
Acting VISN 8 Network Director

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: October 9, 2025

From: Interim Medical Center Director, James A. Haley Veterans' Hospital and Clinics (673)

Subj: OIG Healthcare Facility Inspection of the VA Tampa Healthcare System in Tampa, Florida

To: Interim Network Director, Veterans Sunshine Healthcare Network (10N08)

1. We appreciate the opportunity to review and comment on the OIG draft report of the James A. Haley Veterans' Hospital (JAHVH) in Tampa, Florida. JAHVH concurs with the recommendations and will take corrective action.
2. I have reviewed the documentation and concur with the response as submitted.
3. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(Original signed by:)

David J. VanMeter, FACHE, MHA
Interim Medical Center Director

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Director, VA Tampa Healthcare System (673)

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