US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi

Healthcare Facility Inspection	25-00205-26	December 17, 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 Gulf Coast Healthcare System (facility) from March 18 through 20, 2025.[1] The report highlights the facility's staffing, environment, unique opportunities and challenges, and relationship to the community and veterans served. Below is a summary of findings in each of the domains reviewed.

Culture

The OIG examined several aspects of the facility's culture, including unique circumstances and system shocks (events that disrupt healthcare operations), leadership communication, and both employees' and veterans' experiences. Executive leaders identified key leadership turnover as a system shock that affected the organization's culture.

Leaders stated that since April 2022, the facility experienced turnover in all executive and some service-level leader positions. To support staff during the transitions and listen to their concerns, current executive leaders engaged with them in their work areas. Additionally, facility leaders further communication by holding monthly town halls with live question-and-answer sessions.

The Chief of Staff described participating in weekly meetings to empower staff to suggest solutions to issues. Facility leaders also shared they shifted the organization's culture from placing blame when mistakes occurred to thanking staff who report concerns.

[1] See appendix A for a description of the OIG's inspection methodology. Additional information about the facility can be found in the Facility in Context graphic below, with a detailed description of data displayed in appendix B.

To improve veterans' experience, facility leaders also hold monthly veteran town halls throughout the community, which include resource fairs. Patient advocates explained that veterans provide direct feedback to facility leaders, and staff track complaints to resolution.[2]

Environment of Care

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

The OIG observed ongoing construction in the emergency department and signs provided updated directions to assist with navigation. Additionally, facility staff were instituting a new cleaning process by using ultraviolet machines to disinfect wheelchairs.

However, the OIG found dirty microwaves in the Community Living Center and emergency department patient food storage areas, which was a repeat finding from a previous inspection.[3] The OIG also found women's and unisex restrooms had inoperable feminine hygiene dispensers, and the emergency department's clean supply room contained expired supplies.[4] The OIG made recommendations to improve the facility's environment of care. In response, the Director stated that leaders will regularly audit food storage areas, supply rooms, and restrooms, and report findings to the Quality & Patient Safety Committee until they achieve sustained compliance (see OIG Recommendations and VA Responses).

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight findings and recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found that the facility had established processes to communicate urgent, noncritical tests from providers who order tests to patients, and assign a substitute when an ordering provider was unavailable or had left the facility. However, the facility lacked written workflows detailing the responsibilities of different team members in the

[2] 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/.

[3] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_Community_Living_Centers.

[4] VHA requires public women's and unisex restrooms to have feminine hygiene products available at no charge. VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

communication process, as VHA requires.[5] The OIG made a recommendation to address this deficiency. In response, the Director stated staff are actively developing workflows for all services (see OIG Recommendations and VA Responses).

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.[6]

The OIG found some provider, nursing, and medical support assistant vacancies in primary care teams. Facility leaders told the OIG population growth in the area led to increased enrollment and demand for services, resulting in new patient wait times of 57 days. Leaders addressed staffing gaps with available float providers (staff designated to cover vacancies) and a clinical resource hub.[7] Additionally, leaders shared facility plans to expand space at two clinics.

Staff said requests from community providers added to workload inefficiencies. To address these concerns, primary care and facility leaders shifted some of the workload to specialty providers. Leaders also said clinical pharmacists provided medication management to veterans and administrative staff increased support to providers.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Housing and Urban Development–Veterans Affairs Supportive Housing, and Veterans Justice Programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The Health Care for Homeless Veterans program did not meet the target for veterans receiving an intake assessment in fiscal years (FYs) 2022 or 2023. However, after the program increased staffing, they expanded outreach efforts and exceeded the target in FY 2024.

The facility also missed the FY 2024 target for Veterans Justice Program enrollment, despite referrals and outreach to jails, courts, and community agencies. The OIG learned from a facility

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

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

[7] Clinical resource hubs are "VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities. All 18 VISNs have an established CRH [Clinical Resource Hub] which is supported by a multidisciplinary leadership team." "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed March 25, 2025, https://www.patientcare.va.gov/CRH. Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed February 13, 2025, https://www.va.gov/visns.asp.

leader that in FY 2024, VA increased the facility's target based on the number of veterans enrolled in FY 2023. That year, the program overperformed because a new veterans treatment court opened and other courts increased the number of veteran cases, which increased enrollment.[8] Staff said the new target was unattainable.

What the OIG Recommended

The OIG made four recommendations.

1. The Associate Medical Center Director ensures Environmental Management Services and nutrition staff maintain clean patient food storage areas.
2. The Associate Medical Center Director ensures staff monitor storage areas and remove expired supplies.
3. The Associate Medical Center Director ensures Environmental Management Services staff make feminine hygiene products available in public women's and unisex restrooms.
4. The Chief of Staff ensures staff establish written service-level workflows for the communication of test results.

VA Comments and OIG Response

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

Julie Kroviak MD

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

[8] 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.

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 Gulf Coast Healthcare System
Biloxi, Mississippi
Level 1c-High Complexity
Harrison County
Hospital Referral Region: Gulfport

Description of Community

POPULATION

Female **214,035**	Male **204,928**
Veteran Female **5,860**	Veteran Male **33,487**

Homeless - State **1,196**
Homeless Veteran - State **139**

MEDIAN INCOME

$53,602

EDUCATION

89% Completed High School
60% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **197**

SUBSTANCE USE

20.8% Driving Deaths Involving Alcohol
16.0% Excessive Drinking
169 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
6% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	152,794
Carpool	15,670
Work at Home	6,108
Walk to Work	4,469
Other Means	2,924
Public Transportation	292

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**28 Minutes, 23 Miles**
Specialty Care	**85.5 Minutes, 87.5 Miles**
Tertiary Care	**171 Minutes, 169.5 Miles**

Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **24,968**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	33%
<65 without Health Insurance	19%

Health of the Veteran Population

263 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

22,458

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.39 Days

30-DAY READMISSION RATE

9%

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
21	34

Health of the Facility

UNIQUE PATIENTS

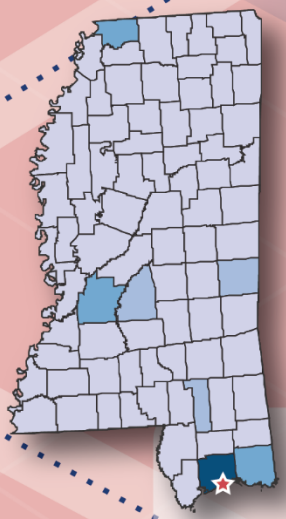
Unique Patients VA and Non-VA Care	87K
Unique Patients VA Care	81K
Unique Patients Non-VA Care	46K

COMMUNITY CARE COSTS

Unique Patient $21,489	Outpatient Visit $461
Line Item $533	Bed Day of Care $329

STAFF RETENTION

Onboard Employees Stay <1 Yr	12.13%
Facility Total Loss Rate	10.48%
Facility Retire Rate	3.04%
Facility Quit Rate	6.62%
Facility Termination Rate	0.68%



★ VA MEDICAL CENTER

VETERAN POPULATION

0.02% 2.76% 5.49% 8.23% 10.96% 13.68%

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]

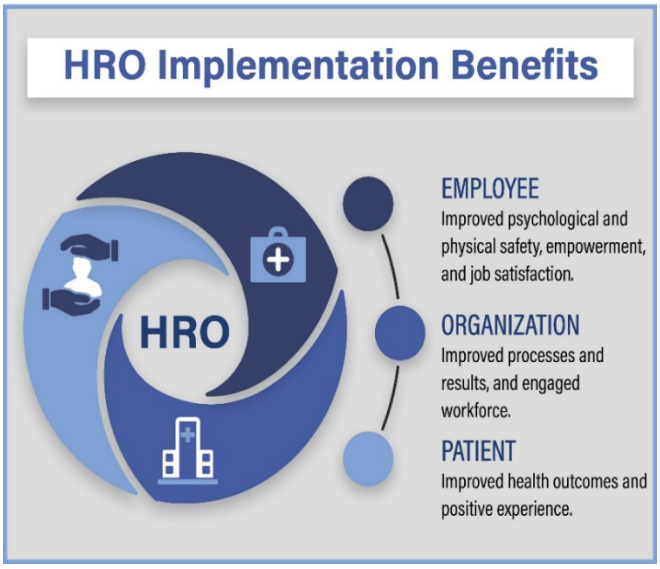


Figure 2. *Potential benefits of HRO implementation. Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.*

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 Gulf Coast Healthcare System (facility) includes the Biloxi VA Medical Center in Mississippi and six outpatient clinics in Alabama and Florida.[13] In fiscal year (FY) 2024, the facility's medical care budget was over $1 billion; it provided care to 92,391 veterans and had 218 operating beds.

The OIG inspected the facility from March 18 through 20, 2025.[14] The executive team consisted of the Medical Center Director (Director), Associate Medical Center Director, Chief of Staff, Associate Director of Patient Care Services, and Associate Director of Outpatient Operations. The executive team had worked together since September 2024, when the Chief of Staff was appointed. The other executive leaders were assigned in 2022 and 2023.

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."[15] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[16] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates.[17]

[13] The outpatient clinics are in Mobile, Alabama, and Eglin Air Force Base, Florida. Panama City Beach, and Pensacola, Florida also have two outpatient clinics each.

[14] 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 above, with a detailed description of data displayed in appendix B.

[15] Valerie M. Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies," *BMJ Quality and Safety* 28 (2019): 74–84, https://doi.org/10.1136/bmjqs-2017-007573.

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

[17] For more information on the OIG's data collection methods, see appendix A. For additional information about the facility, see the Facility in Context graphic above and associated data definitions in appendix B.

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[18] By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[19]

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

The OIG reviewed whether facility staff experienced recent system shocks that affected the organizational culture and whether leaders directly addressed the events that caused those shocks. In an interview, executive leaders identified turnover in key leadership positions as a system shock. The leaders described turnover in all executive leadership positions due to retirements and promotions, as well as vacant service-leader positions, beginning in April 2022.

The Director stated that since they established a stable team, executive leaders have focused on increasing their connection with staff to improve engagement. The Director assigned the Associate Director for Outpatient Operations, a Deputy Chief of Staff, and a Deputy Associate Director for Patient Care Services to the Pensacola clinic, due to its large size, to have leaders on-site. The leader also said they prioritized filling vacant positions to further stabilize the organization. The Director described following through on a commitment to visit every clinic quarterly to support staff, and the full leadership team also visited work areas to listen to staff.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[20] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright

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

[19] Vaughn et al., "Characteristics of Healthcare Organisations Struggling to Improve Quality: Results from a Systematic Review of Qualitative Studies;" Department of Veterans Affairs, *VHA HRO Framework*.

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

culture.[21] Additionally, The Joint Commission identifies communication between administrators and staff as one of the "five key systems that influence the effective performance of a hospital."[22]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with employees, and shared information.[23] The facility's FY 2024 survey scores for information sharing and transparency decreased slightly from previous years, but remained higher than in FY 2021. Executive leaders attributed the decrease in scores to turnover in key leadership positions (executive and service level).

Leaders said losing many experienced leaders at once led them to develop new ways to disseminate information. They collaborated with teams to foster more cohesiveness and productivity. They also held monthly town halls with live question-and-answer sessions open to all employees.

In addition, the Associate Director of Patient Care Services said the nursing service holds monthly town halls, with virtual attendance as high as 250 nurses. However, the associate director acknowledged that employees who work overnight hours are unable to attend town halls during normal business hours. To address this barrier, the nursing supervisor holds a nightly virtual huddle for nurses who work at that time to communicate general information and update them on issues relating to patient care.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[24] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[25] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture

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

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

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

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

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

and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

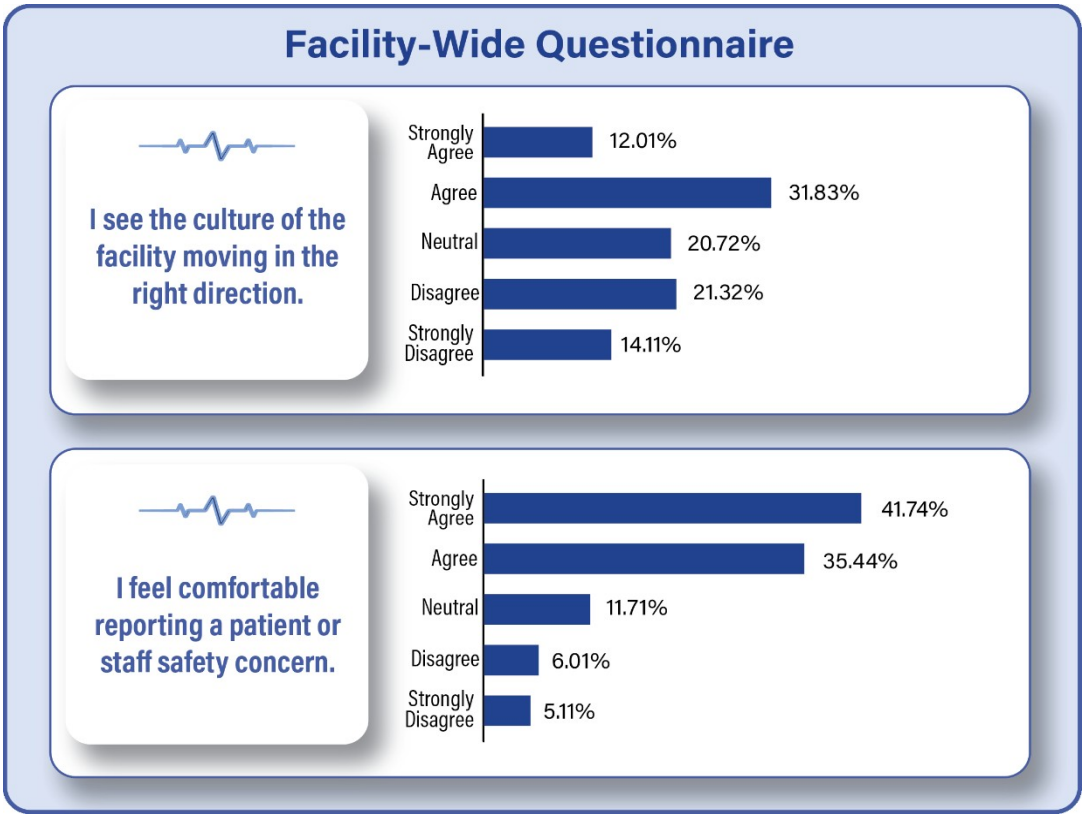


Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

Executive leaders reported they encouraged employees to communicate about problems they identify. The Chief of Staff described meeting weekly with employees to discuss their current issues and empowering them to suggest solutions.

Survey scores for psychological safety generally improved from FY 2021 to FY 2024. Leaders explained they moved the organization away from a culture of blame when employees make mistakes. For example, leaders presented the Great Catch award during monthly town halls to employees who reported a potential adverse event that was a near miss or close call. They also emphasized the importance of reporting safety events and created a link on the facility's internal web page for employees to report concerns, incidents, work orders, or Great Catch nominations.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[26] The OIG reviewed patient advocate reports to understand veterans' experiences with the facility.

A patient advocate respondent to an OIG questionnaire indicated there are specific mechanisms for veterans to provide direct feedback to facility leaders. Executive leaders said veterans submit complaints or questions to patient advocates, who then track complaints until staff resolve them. Leaders also stated they hold monthly veteran town halls in different locations throughout the community to share information. The first hour of each town hall is a resource fair with representatives from different programs, such as Women's Health, Care in the Community, and Housing and Urban Development–Veterans Affairs Supportive Housing.[27] The second hour is a question-and-answer session with the executive leadership team.

Leaders also said they created an orientation booklet for new patients, which provides clinic locations and contact information for various departments, such as Audiology, the Community Living Center, and Dental Services.[28] In addition to the printed booklet, the facility's web page has a link to an electronic copy.

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

[27] "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 April 16, 2025, https://www.va.gov/communitycare/.

[28] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_Community_Living_Centers.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[29] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from 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 6. *Facility photo.*
Source: "Gulf Coast Veterans Health Care System," Department of Veterans Affairs, accessed July 15, 2025, https://vaww.va.gov/directory/guide. (This website is not publicly accessible.)

Entry Touchpoints

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

[29] VHA Directive 1608(1).

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

[31] Department of Veterans Affairs, *Integrated Wayfinding & Recommended Technologies*, December 2012; Department of Veterans Affairs, *VA Signage 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.

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.

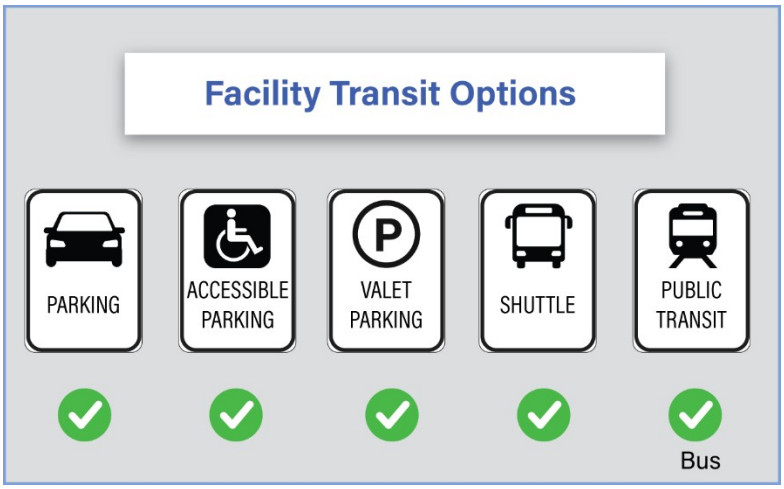


Figure 7. *Transit options for arriving at the facility.*
Source: OIG analysis of documents and observations.

The OIG used directions and interactive maps on the facility's website to easily find the site. A parking garage, located near the main entrance, had parking spaces accessible for those with disabilities, adequate lighting, and emergency call boxes. Facility staff informed the OIG that valet parking, and a VHA shuttle, were available at the main entrance.[32] The OIG observed additional shuttle and bus stop shelters throughout the site and volunteers transporting veterans around the area.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[33]

The OIG noted the main entrance provided shelter and had push-button automatic doors and a passenger loading zone. Information desk staff were available inside the entrance to help veterans get to their appointments. The lobby was welcoming and clean, and had adequate lighting. It also had ample seating and a coffee vendor, as well as wheelchairs, which were clean and in good repair. The OIG observed an ultraviolet machine that disinfects wheelchairs located in the area.[34] Facility staff reported the machine would soon be available for use after staff received training, and leaders planned to place another one in the parking garage.

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[32] Valet services are available 7:00 a.m. to 4:30 p.m., volunteer-operated golf carts run from 7:00 a.m. to 4:30 p.m., and the shuttle bus operates from 8:00 a.m. to 4:30 p.m.

[33] 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*.

[34] Ultraviolet sterilization is a process that uses wavelengths of light to kill microorganisms. Clysly Celine R. Ramos, et al., "Use of Ultraviolet-C in Environmental Sterilization in Hospitals: A Systematic Review on Efficacy and Safety." *International Journal of Health Sciences* 14, no. 6 (2020): 52, https://pmc.ncbi.nlm.nih.gov/articles/PMC7644456/.

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.[35]

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

The OIG noted construction in the emergency department; however, staff had placed signs to direct individuals to various areas. The Chief Engineer reported the construction project was due to be completed within two years. In addition to directional signs related to the construction, there were color-coded maps posted in the main lobby, at elevators, and where main halls intersected, to assist with navigation.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] The OIG noted common areas did not have much background noise, which if present could impede communication for veterans with hearing loss. Elevators had braille, signs with large text, and audio prompts to facilitate navigation by veterans with low vision.

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.[37] Since information desk staff were unfamiliar with the toxic exposure

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

[36] 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.

[37] 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.

screening program, they directed the OIG to primary care staff, who could provide information and conduct screenings.

In an OIG questionnaire, a toxic exposure screening navigator indicated the facility had one navigator in Biloxi, Mississippi, and two in Pensacola, Florida. Staff screen veterans during both primary care appointments and walk-in or phone appointments. Navigators review daily lists of veterans with unresolved (started, but not completed) screenings and contact them to complete the screenings. The facility had no unresolved screenings.

Repeat Findings

Continuous process improvement is one of the pillars of the HRO framework. The OIG expects facility leaders to address environment of care-related recommendations from oversight and accreditation bodies and enact processes to prevent repeat findings.[38]

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

The OIG found dirty microwaves in patient food storage areas in the Community Living Center and emergency department, which is also a finding from a 2022 OIG inspection.[39] The Joint Commission requires staff to use proper sanitation in storing food and nutrition products.[40] Allowing food storage areas to remain dirty may spread pathogens such as bacteria and mold to patients and staff. The Chief of Environmental Management Services said both Environmental Management Services and nutrition staff are responsible for cleaning the areas and attributed the issue to lack of attention to detail. The OIG recommended the Associate Medical Center Director ensures Environmental Management Services and nutrition staff maintain clean patient food storage areas. In response, the Director reported that Environmental Management Services and nutrition leaders will inspect food storage areas to ensure cleanliness (see OIG Recommendations and VA Responses).

General Inspection

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

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

[39] VA OIG, *Comprehensive Healthcare Inspection of the Gulf Coast Veterans Health Care System in Biloxi, Mississippi*, Report No. 22-00074-218, September 29, 2023.

[40] The Joint Commission, *Standards Manual*, E-dition, PC.02.02.03, January 1, 2025.

The OIG found selected clinical areas (medical/surgical units, the critical care unit, and an outpatient clinic) and nonclinical areas (the main entrance and various corridors) to be in good repair, with readily available personal protective equipment and unrestricted access to exits. All inspected medical equipment had evidence of current preventive maintenance, and there was no visible protected patient information.

However, in addition to the dirty food areas mentioned above, the OIG found expired supplies in the emergency department's clean supply room. The Joint Commission requires staff to use safety precautions to prevent infection when storing medical supplies.[41] Supplies used past the manufacturer's expiration date could have damaged packaging or compromised quality. When the OIG asked for a reason the expired supplies were in the clean supply room, facility leaders did not provide an answer. The OIG recommended the Associate Medical Center Director ensures staff monitor storage areas and remove expired supplies. In response, the Director reported that a quality consultant and supply staff will inspect storage rooms to ensure they do not contain expired supplies and adequate stock is available for patient care (see OIG Recommendations and VA Responses).

Additionally, the OIG found the feminine hygiene dispensers in six public women's and unisex restrooms inspected were inoperable, although they were full.[42] VHA requires public women's and unisex restrooms to have feminine hygiene products available at no charge.[43] The Chief of Environmental Management Services was unaware the dispensers were inoperable and stated staff might not check if machines function when they fill them. The OIG recommended the Associate Medical Center Director ensures Environmental Management Services staff make feminine hygiene products available in public women's and unisex restrooms. In response, the Director explained that a quality consultant and Environmental Management Services leaders will inspect restrooms to ensure feminine hygiene products are available (see OIG Recommendations and VA Responses).

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

[41] The Joint Commission, *Standards Manual,* E-dition*,* IC.06.01.01, March 30, 2025.

[42] The OIG inspected four restrooms in the common areas of the facility and two in an outpatient clinic area.

[43] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[44] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[45] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG found the facility has a policy for staff to communicate these results to providers and patients. The policy defines urgent, noncritical results and designates a substitute provider to communicate results if the original provider who ordered the test was unavailable or had left the facility.[46]

However, the facility lacked the required written service-level workflows that detail the responsibilities of different team members in this process.[47] Facility leaders acknowledged they did not have the workflows for all service areas, as required, but they assigned staff to workgroups to develop them. The OIG recommended the Chief of Staff ensures staff establish written service-level workflows for the communication of test results. In response, the Director indicated that staff are actively developing these service-level workflows (see OIG Recommendations and VA Responses).

The OIG also determined the facility has a process to ensure staff convey test results that require action to patients within seven calendar days from the date the results are available.[48] According to facility leaders, quality management staff assess the timeliness of test result communications and ensure staff take corrective actions for identified noncompliance. The Performance Improvement Committee also monitors corrective action plans and reports them to the Quality and Safety Committee each quarter.

In December 2024, facility leaders implemented software specifically developed for VHA to streamline the test result communication process. The software uses templates to automate printing and mailing test result letters to patients. The system had improved efficiency and ensured patients received their results promptly and securely. According to a report provided by

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

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

[46] VHA Directive 1088(1). Gulf Coast Veterans Health Care System, MCP [medical center policy] 11-02-23, *Ordering and Reporting Test Results-Alert Notification and Management*, September 11, 2023.

[47] VHA Directive 1088(1).

[48] Gulf Coast Veterans Health Care System, MCP 11-02-23, *Ordering and Reporting Test Results-Alert Notification and Management.*

facility staff, there was a 53 percent increase in timely communication to patients following the software's implementation.

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.[49] 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 the facility's most recent oversight reports from the OIG and found no open recommendations. Facility leaders credited staff's successful implementation and sustainment of action plans to thorough monitoring by the Continuous Readiness Workgroup. Leaders stated the workgroup convenes monthly to review the status of open action plans, discuss each plan's progress, identify any challenges, and strategize on solutions. Furthermore, the workgroup evaluates previously closed action plans to verify sustained improvement and reports monthly to the Quality and Safety Committee.

Continuous Learning Through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[50] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[51] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Leaders stated patient safety staff identify safety events through the Joint Patient Safety Reporting system.[52] Staff review the events daily to determine the level of patient harm and required action. Leaders then inform staff of steps taken in response to the events during safety forums and town halls.

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

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

[51] VHA Directive 1050.01(1).

[52] The Joint Patient Safety Reporting (JPSR) system is a database VA staff use to report patient safety events. VHA National Center for Patient Safety, *JPSR Guidebook*, October 2023.

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders.[53] 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.[54] 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.[55] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

VHA primary care teams include a provider, registered nurse, clinical associate, and administrative associate, who provide care to an assigned panel (group) of patients.[56] The OIG found 5 provider, 4 registered nurse, 8 licensed practical nurse, and 25 medical support assistant position vacancies across 66 primary care teams. Primary care leaders and staff said there were also several vacant positions for float providers (who cover vacancies and absences), clinical pharmacists, and clinical social workers who support the teams. Primary care leaders attributed the vacancies to staff retiring or taking positions at other VHA or community facilities.

Leaders said they lost five providers at one clinic within a six-week period in 2023 and described the lasting impact on wait times throughout the system. The Deputy Chief of Staff told the OIG that facility clinic locations spanned a long distance, which makes it difficult to share staff. When asked about how they managed the vacancies, facility and primary care leaders said the

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

[54] 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).

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

[56] VHA Directive 1406(2).

Veterans Integrated Service Network (VISN) clinical resource hub and available float providers covered vacant positions.[57]

Primary Care leaders also said they felt supported by executive leaders and human resources staff to address staffing challenges. For example, they offered recruitment and retention incentives such as student loan repayment, paid relocation, and increased initial salary rates for highly qualified staff to compete with community facilities. They further explained several candidates were in various phases of the recruitment process, and they expected to have new registered nurses and providers onboard within weeks. However, facility leaders said the January 2025 federal hiring freeze led to rescinded job offers and delayed onboarding for some of the candidates before VHA offered exemptions.[58] They also stated some recent candidates declined interviews and job offers due to perceived uncertainty in federal employment and hoped this would not become a trend.

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.[59] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[60]

The OIG found primary care panels exceeded expected levels according to VHA guidelines. VHA recommends full-time primary care teams with adequate staffing and space to maintain panels no larger than 1,200 patients.[61] The OIG noted 31 of the 66 teams exceeded 1,200 patients, and 17 teams exceeded 1,400; the largest panel had 1,581 patients.

Facility and primary care leaders said they increased panel sizes to meet growing patient enrollment and demand for services, especially in the Florida panhandle. The Deputy Chief of Primary Care said they needed at least 11 additional primary care teams to meet current and projected enrollment. Facility and primary care leaders added that staff identified the increased workload associated with larger panels in employee surveys, and it contributed to staff burnout and turnover.

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[57] Clinical resource hubs are "VISN-owned and -governed programs that provide support to increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities. All 18 VISNs have an established CRH [Clinical Resource Hub] which is supported by a multidisciplinary leadership team." "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed March 25, 2025, https://www.patientcare.va.gov/CRH. Veterans Integrated Service Networks are "regional systems of care working together to better meet local health care needs and provides greater access to care." "Veterans Integrated Service Network (VISN)," Department of Veterans Affairs, accessed February 13, 2025, https://www.va.gov/visns.asp.

[58] Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025).

[59] "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).

[60] VHA Directive 1406(2).

[61] VHA Directive 1406(2).

Additionally, new patient wait times increased in FY 2024. They initially decreased from 54 days in quarter two to 49 days in quarter three, but then increased to 57 days in quarter four. VHA set a goal for new patient wait times at 20 days.[62] Excessive wait times may delay care and lead to negative patient outcomes.

To reduce patient wait times, leaders said they offered extended appointment hours and Saturday appointments each month for new patients. They also offered veterans' care in the community. Additionally, leaders worked with VISN staff and the Group Practice Manager to identify and address barriers that affect access to care, such as clinic schedules. The OIG recognizes the facility's efforts to address primary care issues and did not make a recommendation.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[63] 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.

Facility and primary care leaders described efforts to reduce staff's workload: clinical pharmacists assisted with medication management and medical support assistants responded to patients' secure messages and scanned and faxed documents for providers. Additionally, facility leaders explained nursing staff were in the early stages of a project to identify options to improve efficiency in the patient walk-in process; leaders also discussed promoting virtual provider visits to reduce the walk-in volume. Leaders anticipated these efforts would reduce workloads.

Further, primary care staff stated that all requests from community providers for additional services had gone to primary care providers, including requests for specialty care services, which added to workloads. Staff shared that leaders were responsive to their concerns and ensured specialty care providers received and completed the appropriate requests, which saved primary care providers' time. The OIG found facility leaders and primary care staff were aware of issues affecting workflow and made efforts to address inefficiencies.

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 that veteran enrollment had increased each year since FY 2022. Facility and primary care leaders explained they had not been able to expand space throughout the facility fast enough to keep up with

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

[63] VHA Handbook 1101.10(2).

enrollment. However, they plan to enlarge existing facilities in Eglin Air Force Base and Panama City and project their completion in FYs 2027 and 2028, respectively.

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.[64]

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).[65] 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."[66]

The facility's program did not meet the target in FYs 2022 or 2023 but exceeded it in FY 2024. Program staff attributed this success to adding an additional outreach coordinator, which allowed program staff to increase outreach to and strengthen relationships with community partners. HCHV staff also said they made additional visits to homeless encampment areas in FY 2024 to identify veterans to enroll in the program.

Staff said they receive referrals from facility staff and community partners; through direct outreach to homeless veterans at shelters, food distribution sites, libraries, and rescue missions (facilities with laundry, food, and computer resources); and participation in the point-in-time

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

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

[66] 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.

count and stand down events.[67] They also coordinate outreach with community partners through a homeless alliance and by-name list (community homeless person list).[68]

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).[69] The HCHV1 and HCHV2 measures count veterans in contracted residential services (community-based agencies that contract with local VA medical centers to provide short-term residential treatment) and low-demand safe haven programs (staffed transitional residencies for chronically homeless veterans with mental illness).[70] The facility did not have data for the measures because it did not have these programs.

When asked about meeting veterans' needs, HCHV staff stated they place veterans in other housing options, including contracted residential services or low-demand safe haven sites located near other VA facilities in the region, if the veterans are willing to travel. Staff also place veterans waiting for permanent housing into bridge housing (with no treatment services) or short-term grant per diem program housing (with substance abuse treatment services), which are also low-demand.[71]

In addition to housing homeless veterans, staff explained they enroll veterans in the facility's primary care services. Staff shared the facility received approval in January 2025 to dedicate a primary care team to homeless veterans. Based on assessments, staff request consultations with facility mental health and residential treatment services and pharmacy staff to meet the needs of

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

[68] A by-name-list is "a single prioritized list that is created through the CoCs [Continuum of Care] coordinated entry process." "How can I use the By-Name List in HomelessData for Housing Prioritization?," HomelessData, May 23, 2023, accessed February 11, 2025, https://www.homelessdata.com/by-name-list-in-homelessdata.

[69] 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*.

[70] VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[71] "Since 1994, GPD [Grant and Per Diem Program] has awarded grants to community-based organizations to provide transitional housing with wraparound supportive services to assist vulnerable Veterans move into permanent housing." VHA Homeless Programs Office, "US Department of Veterans Affairs (VA) Grant & Per Diem (GPD) Program" (fact sheet), July 2022.

individual veterans. Staff indicated they refer veterans who are ineligible for VA healthcare to community resources such as Coastal Family Health, which has a homeless clinic with primary care, mental health, dental, and optometry services. They also said they work with community partners to help veterans access food, clothes, toiletries, housing goods, and addresses for mail delivery.

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."[72] 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.[73]

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).[74] The facility did not meet the target for FYs 2022 through 2024, which program staff attributed to a lack of affordable housing in the facility's service area. They stated landlords increased rents after the COVID-19 pandemic and received more money renting at market value than renting to veterans who use vouchers, so they did not renew some veterans' leases.

To address this barrier, the program manager said they developed relationships with landlords by attending landlord fairs and association meetings, where they educated them about the program. Staff reported the Department of Housing and Urban Development approved an increase in voucher amounts in 2024. As a result of outreach and the increased voucher rates, staff explained landlords have returned to the program and the number of veterans using vouchers has increased.

In addition, program staff stated the low number of homeless veterans in the Eglin area led to unused vouchers there, and the public housing authority office transferred some of them to another locality with a higher need in 2024. This helped bring the facility's HMLS3 score to less than 4 percent below the target that year. Staff recognized a similar situation in Biloxi, where

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

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

[74] 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*.

vouchers were available for housing within city limits but not outside the city, where some veterans prefer to live to be close to family or friends. The Homeless Program Manager explained that program staff are in discussions with the Department of Housing and Urban Development to move some unused Biloxi vouchers to the public housing authority's regional office for veterans who prefer not to live in the city. Staff anticipate the voucher relocation will improve their ability to meet the target and ensure vouchers are available where the need is.

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).[75] The facility met the targets for FYs 2022 through 2024.

Program staff attributed meeting the target to early identification of veterans' interest in employment during HCHV intake assessments and good relationships with employment partners. The assistant homeless program manager reported that HCHV staff identify veterans' employment preferences when they enroll and refer them to homeless program staff, like rehabilitation counselors, peer support staff, and employment specialists, who help them write resumes, locate job opportunities and job fairs, and prepare for interviews. Program staff also transport veterans to job interviews. Staff reported they work closely with Compensated Work Therapy–Transitional Residence program staff to employ veterans once they have stable housing.[76] Staff also explained many veterans are already employed when they enroll in the Housing and Urban Development–Veterans Affairs Supportive Housing program.

In addition to housing and employment, staff told the OIG they referred veterans to facility staff for healthcare and mental health services and educate groups of them on various health topics. Staff emphasized the importance of these groups for socialization because elderly veterans' mental health declines when they are isolated.

Additionally, staff said they obtained resources for veterans, such as bicycles for transportation. Recently a case manager acquired a motorized wheelchair for a veteran who had a double above-the-knee leg amputation. Staff reported many veterans successfully exit the program to permanent housing and no longer require assistance.

[75] 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*.

[76] The Compensated Work Therapy-Transitional Residence program "provides time-limited transitional housing with supportive employment services to homeless veterans with mental health and substance use disorders, co-occurring medical concerns, and psychosocial needs including homelessness and unemployment." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[77] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[78]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[79] The facility exceeded the target in FY 2023 but did not meet it in FY 2024. Program staff told the OIG that during FY 2023, a new veterans treatment court opened, and dockets reserved for veterans at other courts expanded, helping to increase enrollment.[80] In addition, staff enrolled veterans they had worked with in FY 2023 who were not previously in the program's database, which helped the program exceed the target that year. However, program staff stated VA had increased the facility's FY 2024 target based on the number of veterans enrolled in FY 2023. The staff said the new goal was unattainable since the program was already performing at a high level in FY 2023 due to court expansions and enrollment of veterans.

A program staff member explained they also received referrals from staff at the facility, courts, jails, community agencies, and work release programs, as well as friends and family of incarcerated veterans and other veteran inmates. In response to an OIG questionnaire, staff stated they conduct weekly outreach to local jails, courts, probation offices, homeless shelters, and law firms; and at events such as the facility's Whole Health and Resource fair; and community work release meetings.

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

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

[79] 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*.

[80] 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. "A court docket is the official record of a case's journey through the court system, providing a comprehensive timeline of events from initiation to resolution." "What Is a Court Docket and How Does It Work?," Legal Clarity, accessed August 18, 2025, https://legalclarity.org/what-is-a-court-docket-and-how-does-it-work/.

Meeting Veteran Needs

Program staff explained that coordination is a large part of their work. They described working with veterans in six veterans treatment courts. Additionally, they address veterans' treatment needs by collaborating with facility mental health providers. They submit facility consults or community referrals to obtain treatment, monitor veterans' progress, and report back to the courts for monitoring and oversight. Program staff also communicate with facility staff to schedule appointments and contact jail staff, judges, and law enforcement officers to allow incarcerated veterans to attend treatment programs.

Further, staff work with incarcerated veterans six months prior to their release, identify their pre- and post-release needs, help them apply for VA health care, and connect them to community resources. These include shelters or transitional housing if the veteran would be homeless after release.

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 cleanliness, supplies, hygiene products, and test result communication. Facility leaders have started to implement corrective actions (see OIG Recommendations and VA Responses). Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

OIG Recommendations and VA Responses

Recommendation 1

The Associate Medical Center Director ensures Environmental Management Services and nutrition staff maintain clean patient food storage areas.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Food Storage areas were immediately cleaned. Staff were reminded in Tier 1 huddles to maintain clean and safe food storage areas. Food storage area inspection was implemented to include daily clinical staff rounding to verify cleanliness and documentation of any corrective action needed. Beginning December 1, 2025, Quality Consultant and EMS leadership will conduct a weekly audit of inspections of ten (10) food storage areas to ensure compliance and data collected will be reported to the Quality & Patient Safety Committee monthly until 90% compliance has been reported for six consecutive months.

Recommendation 2

The Associate Medical Center Director ensures staff monitor storage areas and remove expired supplies.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

The identified expired supply was immediately removed from the storage area. Supplies and par levels have been reviewed and adjusted to ensure valid supplies in sufficient quantities are available to staff for patient use. To maintain compliance, weekly storage area Inspection beginning December 1, 2025, will be implemented to include clinical staff and supply chain staff rounding to identify and remove expired supplies, hoarding /excessive supplies and documentation of any corrective action needed. Quality Consultant and Supply will complete monthly audits of Storage area inspections of ten (10) supply storage areas beginning December 2025 to ensure compliance of at least 90% for six months and provide monthly report of data collected to the Quality & Patient Safety Committee.

Recommendation 3

The Associate Medical Center Director ensures Environmental Management Services staff make feminine hygiene products available in public women's and unisex restrooms.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

Feminine hygiene products have been supplied in public and unisex restrooms. EMS Chief has implemented a daily inspection to ensure feminine hygiene products are stocked, dispensers are functional, and corrective actions are documented as indicated. To ensure compliance, Quality Consultant and EMS leadership will complete monthly audits of the daily inspections of ten (10) women's and/or unisex restrooms beginning December 2025 to ensure compliance of at least 90% for six months and provide monthly report of data collected to the Quality & Patient Safety Committee.

Recommendation 4

The Chief of Staff ensures staff establish written service-level workflows for the communication of test results.

_X_ Concur

____ Nonconcur

Target date for completion: June 30, 2026

Director Comments

In response to this recommendation, the Chief of Staff will update and communicate workflows for communication of test results in compliance with VHA Directive 1088(1), Communicating Test Results to Providers and Patients, dated July 11, 2023 (Amended September 20, 2024) by December 31, 2025. The Chief of Staff will ensure the service-level workflow for test results communication includes service, responsibilities of team members and standard timeframes GCVHCS requirements via service level Standard operating procedure. 100% of all services will be included in the audit schedule by January 31, 2026. Monthly audits will be performed by COS Leadership and Quality Consultant to ensure all services include required workflows. Compliance with this item will be monitored and reported to the Quality & Patient Safety Committee monthly until 90% compliance has been reported for six consecutive months.

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 March 18 through 20, 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: December 2, 2025

From: Interim Network Director, South Central VA Health Care Network (10N16)

Subj: VA OIG DRAFT REPORT: Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi

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

Chief Integrity and Compliance Officer (10OIC)

The South Central VA Health Care Network (10N16) has reviewed and concurs with the facility's response to the four (4) recommendations contained in the VA OIG Draft Report of the Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi.

(Original signed by:)

Fernando O. Rivera, FACHE

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 2, 2025

From: Director, VA Gulf Coast Healthcare System (520)

Subj: Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review and respond to the draft report Healthcare Facility Inspection of the VA Gulf Coast Healthcare System in Biloxi, Mississippi.
2. I have reviewed the draft report and concur with the recommendations, noting the thorough evaluation by the OIG.
3. For questions regarding information provided, please contact the Chief, Quality & Performance Management.

(Original signed by:)

Stephanie A. Repasky

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Miquita Hill-McCree, MSN, RN, Director Edna Davis, BSN, RN Megan Magee, MSN, RN Carol Manning, MSW, MPH
Other Contributors	Kevin Arnhold, FACHE Jolene Branch, MS, RN Richard Casterline Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Daphney Morris, MSN, RN Sachin Patel, MBA, MHA Ronald Penny, BS Joan Redding, MA Larry Ross Jr., MS April Terenzi, BA, BS Dan Zhang, MSC

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