US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Bay Pines VA Healthcare System in Florida

Healthcare Facility Inspection	26-00033-168	August 5, 2026

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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 VA Office of Inspector General (OIG) established the Healthcare Facility Inspection program to review Veterans Health Administration (VHA) medical facilities on an approximately three-year cycle. The OIG inspected the Bay Pines VA Healthcare System (the facility) from December 16 through 18, 2025. The facility is rated as *highest complexity* and in fiscal year 2025, provided direct care to 109,869 unique patients.[1] The inspection team examined aspects of care delivery and patient safety within the facility using five domains.[2]

What the OIG Examined

Overall, the OIG inspection did not reveal concerns that warranted recommendations for corrective action in any of the five domains.

- **Culture.** The inspection focused on system shocks (events that disrupt healthcare operations) and both employees' and veterans' experiences.
- **Environment of Care.** Inspectors examined the main entrance and patient care areas for safety, cleanliness, infection prevention, accessibility, and privacy.
- **Patient Safety.** The team ascertained whether the facility had processes to communicate test results, respond to oversight recommendations, and identify opportunities for improvement.
- **Integrated Veteran Care.** To assess primary and community care services, the team considered staffing levels, veterans' access to care, and process improvements.[3]
- **Veteran-Centered Safety Net.** The inspection also evaluated facility programs that offer support services to vulnerable veterans who are experiencing or at risk of homelessness, or recently incarcerated.

[1] VHA classifies facilities based on their complexity level. Highest-complexity facilities have high-volume, high-risk patients, many complex clinical programs, and large research and teaching programs. VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed March 26, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[2] See appendix A for a description of the OIG's inspection methodology.

[3] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

What the OIG Recommended

The OIG did not make any recommendations.

VA Comments and OIG Response

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

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Assistant Inspector General
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Abbreviations

FY	fiscal year
HCHV	Health Care for Homeless Veterans
HUD-VASH	Housing and Urban Development–Veterans Affairs Supportive Housing
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Contents

Introduction

The Office of Inspector General's (OIG's) Office of Healthcare Inspections focuses on overseeing the Veterans Health Administration (VHA), which offers care to more than nine million enrolled veterans through its 1,380 healthcare facilities.[4] VHA's vast care delivery structure requires sustained and thorough OIG oversight to ensure the nation's veterans receive high-quality care.

The OIG established the Healthcare Facility Inspection program to routinely evaluate VHA medical facilities on an approximately three-year cycle. Healthcare Facility Inspection reports provide insight into the experience of staff working in VHA facilities and veterans receiving care. They inform veterans, the public, and Congress about the conditions for care delivery and patient safety and highlight specific corrective actions leaders and staff can take. Each inspection focuses on five domains and assesses facilities' adherence to VA standards and other governing authorities:

Culture: VA supports a system of shared values that shape an organization's behavioral norms. Effective responses to system shocks as well as favorable employee and veteran experiences are elements of positive organizational culture.[5]

Environment of Care: Medical facilities must maintain safety, cleanliness, and accessibility. VHA established a comprehensive program that addresses physical spaces, equipment and systems, privacy, and other concerns.[6]

Patient Safety: VHA programs identify and reduce system vulnerabilities and risks of harm to veterans.[7]

Integrated Veteran Care: Facilities must comply with directives and guidance governing the VHA multidisciplinary care model.

Veteran-Centered Safety Net: VA offers coordinated medical care and social support services to vulnerable individuals, including those experiencing homelessness or recent incarceration.[8]

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[4] "About Us," VA, last updated June 2, 2026, https://department.va.gov/vha/about-us.

[5] Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11, https://doi.org/10.1136/bmjopen-2017-017708.

[6] VHA Directive 1608(1), *Comprehensive Environment of Care Program*, June 21, 2021, amended September 7, 2023.

[7] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

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

The Bay Pines VA Healthcare System (the facility), which opened in March 1933, includes the C.W. Bill Young VA Medical Center and eight community-based outpatient clinics.[9] In fiscal year (FY) 2025, the facility's medical care budget was approximately $1.7 billion, and it had 169 inpatient, 106 domiciliary, and 112 community living center beds.[10]

Figure 1. *Facility photo.*
Source: "VA Bay Pines Health Care," VA, accessed December 4, 2025, https://www.va.gov/bay-pines-health-care.

The OIG inspected the facility from December 16 through 18, 2025. The executive leaders referred to throughout this report included the Acting Medical Center Director (Acting Director); Acting Deputy Director; Associate Director; Associate Director for Patient Care Services; Chief of Staff; and Acting Assistant Director.

CULTURE

The OIG team examined the facility's culture across multiple dimensions, including unique circumstances and system shocks (planned or unplanned events that disrupt an organization's daily operations), and both employees' and veterans' experiences.[11] The OIG administered its own facility-wide questionnaire and reviewed Veterans Signals (VSignals) survey scores (which summarize real-time information from veterans about their experiences after an appointment and

[9] "Locations," VA, accessed December 4, 2025, https://www.va.gov/bay-pines-health-care/locations.

[10] A domiciliary is a residential "clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans," VA, last updated June 23, 2026, https://department.va.gov/homeless/dchv. A community living center is also referred to as a VA nursing home. "Geriatrics and Extended Care," VA, last updated March 27, 2026, https://www.va.gov/clc. "Trip Pack - Operational Statistics Table FY2026 Through February," VHA Support Service Center, accessed March 26, 2026, https://reports.vssc.med.va.gov/OperationalStatisticsTable. (This web page is not publicly accessible.)

[11] 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.

assess their level of trust in VA).[12] The team also interviewed executive and facility leaders and employees and considered data from patient advocates.[13]

System Shocks

Respondents to the OIG questionnaire identified back-to-back hurricanes and executive orders and presidential memorandums as major system shocks. In 2024, two hurricanes, Helene in September and Milton in October, struck the facility. With Hurricane Milton, it was necessary to evacuate community living center and domiciliary patients to the other VA facilities. Executive leaders and staff told the OIG that rebuilding efforts continued at the time of the inspection in December 2025.

The facility liaison reported that executive orders and presidential memorandums that affected the facility included termination of probationary staff, workforce reductions through deferred resignations, a hiring freeze (in effect from January 20, 2025, to October 15, 2025), and the return-to-office mandate.[14] Executive leaders and staff said they faced challenges addressing staff concerns due to limited available information at the time of order and memo issuance but communicated through weekly town halls and facility-wide emails.

Employee Experiences

Most respondents to the OIG questionnaire said they stayed at the facility because of the VA mission, pay and benefits, and job satisfaction. When asked what might make them leave, 37 percent cited stress and burnout, while approximately 36 percent said they had no plans to leave. About 41 percent felt the facility's culture was moving in the right direction, and more than half answered they felt comfortable suggesting actions to improve their work environment.

[12] "Veteran Trust in VA," VA, last updated June 4, 2026, https://www.va.gov/initiatives/veteran-trust-in-va.

[13] Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Patient Advocate," VA, last updated May 9, 2022, https://www.va.gov/patientadvocate. For more information on the OIG's data collection methods, see appendix A.

[14] VHA placed full-time employees who accepted the Deferred Resignation Program on paid administrative leave until September 30, 2025, unless they were eligible to retire earlier. Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies, January 28, 2025. Hiring Freeze, 90 Fed. Reg. 8247 (Jan. 28, 2025). Shortly after the hiring freeze memorandum was issued, the Acting Secretary provided guidance and identified a list of exempted "positions critical to delivering care to Veterans in" VHA. Acting Secretary, "Hiring Freeze Guidance," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, January 21, 2025. As of December 1, 2025, VA adopted new policies for filling vacancies and creating new positions in compliance with the executive order for Ensuring Continued Accountability for Federal Hiring. Executive Order 14356, 90 Fed. Reg. 48387 (Oct. 20, 2025); Assistant Secretary for Human Resources and Administration (006), "Updated Department of Veterans Affairs Hiring Guidance (VIEWS 13474675)," memorandum to Under Secretaries, Assistant Secretaries, and other key officials, December 1, 2025.

To further engage employees and improve their experiences, the Acting Assistant Director said executive leaders launched the Vibe Tribe program. Through the program, leaders said they plan to use a quarterly questionnaire to measure employee satisfaction and improve morale through program activities such as the selection of a facility mascot.

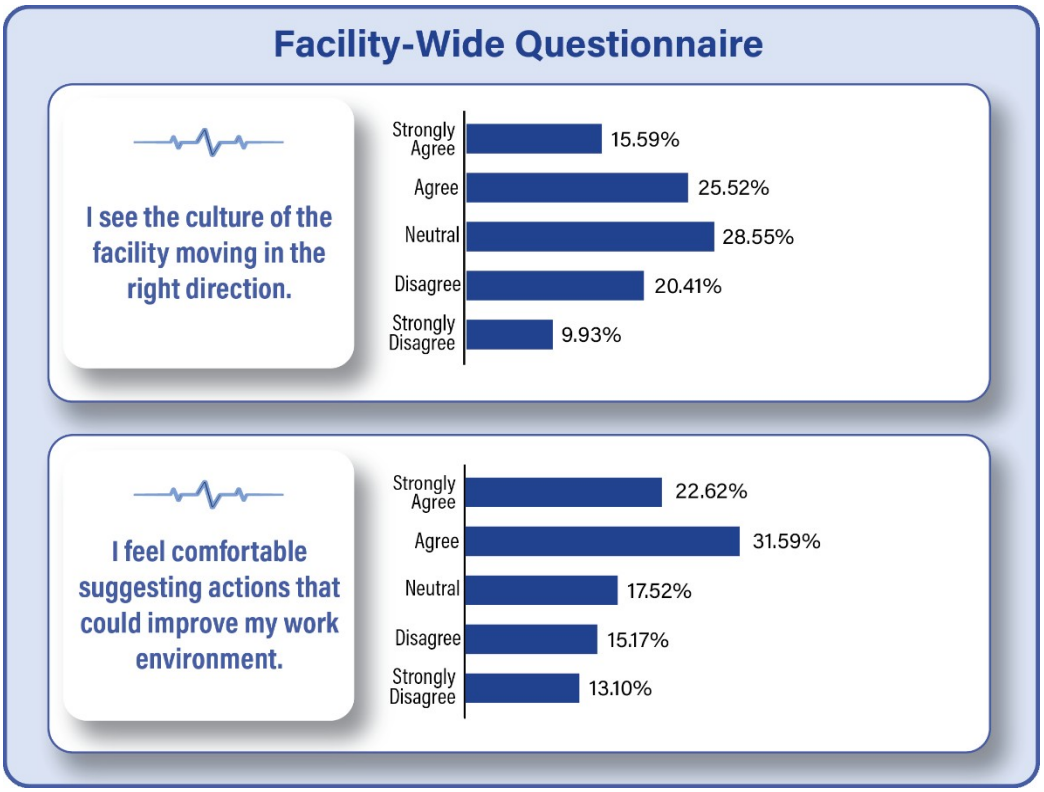

Figure 2. *Employees' perceptions of facility culture.*
Source: OIG analysis of selected questionnaire responses.

Veteran Experiences

The facility's VSignals average trust scores were nearly identical to the VHA average in the first through third quarters of FY 2025 (about 94 percent favorable rating), indicating that veterans trust the facility and have confidence in the outpatient care provided. The acting veterans experience officer said leaders were proud to meet the VHA average for FY 2025 and shared the scores widely through regular employee town halls, new employee orientations, and meetings.

In an OIG questionnaire, patient advocates identified veterans' most common complaint as telephone wait times. The Acting Deputy Director acknowledged a new telephone system had technical glitches that dropped calls and increased wait times to answer in 2023. They corrected those problems, which reduced wait times, and complaints subsequently decreased. Additionally, leaders shared that call center staff now answer incoming calls rather than having all calls go directly to clinics, where staff may be busy with patient care and scheduling appointments.

ENVIRONMENT OF CARE

Attention to environmental design improves veterans' and staff's safety and experience.[15] The OIG team assessed how a facility's physical features may shape the veteran's perception of the health care they receive. The team also inspected patient care areas and focused on safety, cleanliness, infection prevention, and privacy.

The inspectors examined compliance with key VA and VHA guidelines and standards, as well as with Architectural Barriers Act and Joint Commission standards. Best practice principles from academic literature were also considered.[16]

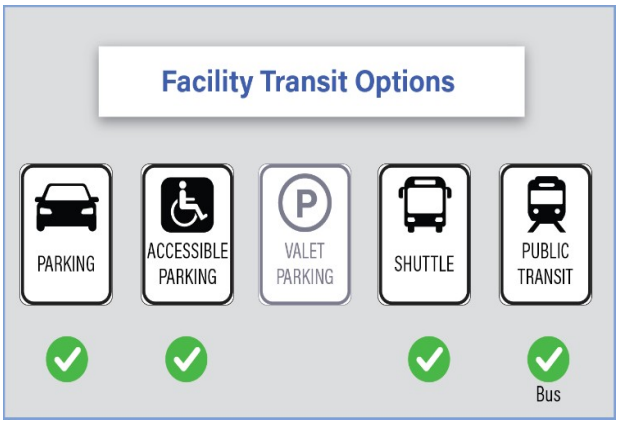

Figure 3. *Transit options for arriving at the facility. Source: OIG analysis of facility parking and shuttle documents; Bay Pines facility map; and Bay Pines, Manatee, and Pinellas Suncoast transportation websites.*

General Inspection

The facility had ample parking options, including a garage and designated accessible spaces. Transportation options included Veteran and Volunteer Transportation Services (rides for veterans to and from appointments), wheelchair-accessible shuttles, and public bus routes via Manatee County Area Transit and Pinellas Suncoast Transit Authority.

The main entrance featured a covered passenger drop-off zone, power-assisted doors, and clear exterior signs. Information desk volunteers provided directions, offered wheelchairs, and transported veterans to their destinations.

Patient care areas had no privacy issues. The facility provided assistive listening systems and other accessibility tools. The facility also had large directional markers and wall maps that identified department locations throughout the facility. However, the main entrance directory did not list primary care clinics. Leaders acknowledged the concern and reported that a project to update signage was underway. Because of the ongoing project, the OIG did not make a recommendation.

[15] "Informing Healing Spaces through Environmental Design: Thirteen Tips," VA, last updated May 1, 2024, https://www.va.gov/WholeHealth/Healing-Spaces.

[16] VA, *Integrated Wayfinding & Recommended Technologies*, December 2012; VA, *VA Signage PG-18-10, Design Manual*, May 16, 2023, revised February 19, 2025; VA, *VA Barrier Free Design Standard*, January 1, 2017, revised May 1, 2025; VHA, *VHA Comprehensive Environment of Care (CEOC) Guidebook*, 2025; Access Board, *Architectural Barriers Act (ABA) Standards*, 2015; The Joint Commission, *Standards Manual*, E-dition, EC.02.06.01, July 1, 2025.

The OIG inspectors examined the facility's patient safety processes. They focused on communication procedures for urgent but noncritical test results, the sustainability of changes made by leaders in response to previous oversight recommendations, and improvement projects.

Communication of Urgent but Noncritical Test Results

The facility had established processes to notify healthcare providers who order tests about urgent but noncritical test results; follow up with patients; assign a designee when a provider was unavailable or had left the facility; and transmit results outside regular clinic hours and during care transitions, as required by VHA Directive 1088(1), *Communicating Test Results to Providers and Patients*. The facility also had written service-level workflows that outlined team members' roles in communicating test results.[17]

In an interview, the Chief of Staff explained that leaders monitor electronic health records for laboratory and imaging result notifications (alerts). Weekly reports track alerts pending action for more than 7, 14, and 30 days. Leaders educate providers about the importance of promptly reviewing test results. Primary care leaders also filter notifications in electronic health records that do not require providers' attention to decrease the volume of notifications they receive.

Action Plans and Process Improvements

The team reviewed the facility's most recent oversight reports from the Joint Commission and the OIG.[18] The team did not identify prior findings related to the communication of test results, and no recommendations remained open for more than one year. The Acting Director emphasized the importance of maintaining flexible and timely communications, rather than relying solely on scheduled meetings. Leaders also used town halls, rounds, office hours, and presentations as forums to share lessons learned and best practices with staff.

During an interview, patient safety and systems redesign personnel said they collaborated with frontline staff to identify potential process improvement projects and raise awareness about the need to report concerns. Patient safety staff noted there were increases in safety event reports (including conditions that increase the risk to patients) and decreases in adverse patient outcomes (such as delays in care and patient harm) from FY 2024 to FY 2025. Systems redesign staff provided an example of a project called *Improving Record Management Process for VACC*

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

[18] VA OIG, *Comprehensive Healthcare Inspection of the Bay Pines VA Healthcare System in Florida*, Report No. 22-04014-130, April 10, 2024; The Joint Commission, *Final Accreditation Report Bay Pines VA Healthcare System Hospital*, *Behavioral Health Care and Human Services*, *Home Care*, May 17, 2025.

[Community Care] Diagnostic Imaging (CT Scans).[19] This project ensured staff closed CT scan consults (referrals) within 90 days and reduced the average turnaround time to 8 days, which resulted in faster communication of results to VHA providers.

VHA's Office of Integrated Veteran Care manages veterans' access to health care in both VA and community facilities.[20] The OIG evaluated facilities' primary care and community care staffing, veterans' access to care, actions staff took to enhance processes, and how leaders supported improvements. The inspection team also examined community care referral processing timelines and program effectiveness in improving access to care.

Primary Care Staffing and Access to Care

At the time of the inspection in December 2025, primary care leaders reported staffing vacancies across 84 teams, including eight healthcare providers, five registered nurses, two licensed practical nurses, and six medical support assistants. They noted that many staff had retired or transferred to other VA or private facilities. Leaders were actively recruiting for all positions and interviewing several candidates in mid-December 2025. Primary care teams were using part-time staff and Clinical Resource Hub providers for virtual and in-person care to help address workload.[21] Clinic staff also covered multiple teams when needed.

The facility's average wait time for new patient appointments in the first through third quarters of FY 2025 was under 20 days, which under the Code of Federal Regulations (title 38, section 17.4040) meant patients did not meet wait-time criteria for being referred to community providers (more than 20 days).[22] In an interview, the management analyst for primary care described reviewing wait times monthly with primary care leaders. Two new patient appointment slots were reserved per team daily to ensure veterans had timely access to care. Seasonal demand for VA health care rises in winter when many veterans who live elsewhere travel to Florida, but wait times have remained stable.

The chief of primary care reported monitoring primary care panels (the number of patients assigned to a care team) monthly and adjusting them as needed to balance workload among

[19] VA offers health care through community providers when it is not available at the facility or because of drive or wait times. VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, § 101, 132 Stat. 1393.

[20] "Community Care," VA, accessed June 29, 2026, https://department.va.gov/vha/community-care.

[21] Clinical Resource Hubs "increase access to VHA clinical services for Veterans when local facilities have gaps in care or service capabilities." "Clinical Resource Hubs (CRH)," VA, last updated March 20, 2024, https://www.patientcare.va.gov/CRH.

[22] 38 C.F.R. § 17.4040 (2025).

teams.[23] Staff said panel sizes are reasonable, but they struggle to provide care for walk-in patients. Primary care leaders launched a pilot program with dedicated providers to see walk-in patients and reduce schedule disruptions.

Community Care Staffing and Access to Care

Community care program leaders within the facility reported 11 vacancies (7 administrative and 4 clinical) and said some staff left due to the deferred resignation program and return-to-office mandate.[24] The leaders added that they were actively recruiting but the hiring freeze and lengthy human resources processes delayed filling the positions.[25]

Providers referred patients to community providers mainly for long drive times (from the patient's home to the facility), extended appointment wait times, or services unavailable at the facility. In the third quarter of FY 2025, most referrals were for radiology (imaging to detect and treat medical conditions), surgery, and optometry (eye care services).[26] Leaders attributed increased radiology referrals partly to the loss of radiologists after the return-to-office mandate, but they said a new radiologist was in the hiring process as of mid-December 2025.

The team found it took staff an average of 14 days to schedule appointments in the community, which exceeded the 7-day requirement in VHA's *Consult Timeliness Standard Operating Procedure*.[27] Leaders cited staffing vacancies, high referral volume, limited local provider availability, and time-consuming coordination with community providers as contributing factors.

To address backlogs, leaders said they authorized weekend overtime and other initiatives to improve timeliness. For example, program leaders told the OIG they encouraged veterans to self-schedule for appointments and engaged community providers to increase participation in the Health Share Referral Manager (a free tool that allows community providers to submit medical records needed for scheduling and to communicate with VA staff). Because of these actions to address timeliness, the OIG did not make a recommendation.

[23] "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).

[24] Acting Director, Office of Personnel Management, "Guidance Regarding Deferred Resignation Program," memorandum to Heads and Acting Heads of Departments and Agencies; Return to In-Person Work, 90 Fed. Reg. 8251.

[25] Hiring Freeze, 90 Fed. Reg. 8247.

[26] *Merriam-Webster*, "Radiology," accessed April 8, 2026, https://www.merriam-webster.com/radiology; *Merriam-Webster*, "Optometry," last updated April 6, 2026, https://www.merriam-webster.com/optometry.

[27] VHA Office of Integrated Veteran Care, "Consult Timeliness Standard Operating Procedure (SOP)," October 2, 2025.

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

Health Care for Homeless Veterans

According to VHA, the HCHV program aims to reduce homelessness by improving access to health care, based on the premise that addressing health needs enables veterans to pursue broader life goals. Program staff provide outreach, case management, and referrals to VA or community-based residential programs for specialized treatment.[28]

VHA uses performance measures to determine the success of each medical facility's program. HCHV1 measures the percentage of veterans placed into permanent housing from contracted emergency residential services (stable living arrangements for veterans while they seek permanent housing) as well as those from low-demand safe haven programs (transitional residences for veterans with mental health or substance use conditions).[29] HCHV2 measures the percentage of veterans who are discharged from the program's contracted emergency residential services or low-demand safe haven beds due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff (referred to as negative exits)."[30]

Performance and Improvement Highlights

- The program met the exit to permanent housing (HCHV1) and negative exit (HCHV2) targets for FY 2025. Facility program staff explained they collaborated

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

[29] VHA sets targets for HCHV1 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*, November 2024. Contract residential services programs include both contracted emergency residential services and low-demand safe haven programs. For contracted emergency residential services, veterans can usually stay from 30 to 90 days. For low-demand safe havens a veteran can typically stay between 4 to 6 months. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

[30] VHA also sets targets for HCHV2 at the national level each year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

with the HUD-VASH and Supportive Services for Veteran Families programs to successfully house veterans.[31]

- Program staff said the facility has a dedicated homeless primary care team that accepts walk-ins during the week. The program also operates a mobile medical unit equipped with an exam table, medical supplies, and refrigerated medications for outreach activities on Tuesdays and Fridays.
- A program staff member discussed the long travel times and limited shelter and public transportation options for veterans in rural areas. Additionally, hurricanes disrupted access to shelters, health care, and other essential services. Before and after severe weather, staff contacted veterans to assess their needs for food, housing, transportation, safety, and medications. Staff also followed up and secured resources for veterans who required additional support.

Housing and Urban Development–Veterans Affairs Supportive Housing

The HUD-VASH program combines HUD rental assistance with VA case management services to support veterans who face significant barriers to stable housing, including "serious mental illness, physical health diagnoses, and substance use disorders."[32] The program uses the Housing First approach to prioritize rapid placement into housing followed by individualized services.[33]

VHA measures how well the program meets veterans' needs by using nationally determined targets, including the number of housing vouchers assigned to the facility currently used by veterans or their families (performance measure HMLS3) and the percentage of veterans who are employed (performance measure VASH3).[34]

Performance and Improvement Highlights

- The program did not meet the voucher use (HMLS3) target for FY 2024 but achieved the target in FY 2025. Facility program staff attributed earlier shortfalls to

[31] Supportive Services for Veteran Families provides case management and support to prevent homelessness, "or to rapidly re-house veterans and their families." "Supportive Services for Veteran Families," VA, accessed March 19, 2026, https://department.va.gov/homeless/ssvf.

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

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

[34] VHA sets the target for facilities to provide a minimum of 90 percent of their allotted housing vouchers to participants and at least 50 percent of the participants in the facility's program should be employed. VHA Homeless Programs Office, *Technical Manual: FY 2024 Homeless Performance Measures*, October 1, 2023; VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures*.

staffing vacancies, lack of affordable housing, and delays with public housing agencies.

- Staff credited meeting the employment (VASH3) target for FY 2025 to a facility program employment specialist who provided job referrals and offered résumé and interview coaching.
- Facility program staff said the HUD-VASH program had 20 housing units that included shuttle services, medical and dental care, a clubhouse with a gym, computers, and free laundry services for low-income veterans. Community organizations provided household goods such as small kitchen appliances, curtains, bedding, and furniture; bicycles; food; and financial assistance to veterans for deposits, utilities, application fees, background checks, and transportation.

Veterans Justice Program

The Veterans Justice Program serves veterans throughout all stages of the criminal justice process—from contact with law enforcement to court appearances and their reentry into life in the community after incarceration.[35] Recognizing incarceration as a strong predictor of homelessness on release, the program focuses on connecting veterans to VA health care, services, and benefits. VHA sets a target for the number of veterans entering the Veterans Justice Program each fiscal year (performance measure VJP1).[36]

Performance and Improvement Highlights

- A facility program staff member said they met the enrollment (VJP1) target for FY 2025, after one of the two coordinators returned from extended leave. Facility program staff conducted outreach at jails, public defenders' offices, and law enforcement agencies. They also attended quarterly task force meetings where community partners made services available for veterans in the program. For example, one partner offered to care for a veteran's service dog during the veteran's post-incarceration treatment program. Another organization, Paws in Paradise, cared for an incarcerated veteran's cat free of charge.
- In support of veterans in six treatment courts, the program lead said staff reviewed medical records and met with court case managers and coordinators before court

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

[36] VHA sets escalating targets for this measure at the facility level each year, with the goal to enroll all identified veterans by the end of the fiscal year. VHA Homeless Programs Office, *Technical Manual: FY 2025 Homeless Performance Measures.*

sessions to address issues.[37] The program lead provided early intervention for at-risk veterans to prevent arrests and incarceration and worked with law enforcement to divert veterans from jail.

Conclusion

To assist leaders in evaluating the quality of care at the Bay Pines facility, the OIG conducted an inspection across five domains. Based on the overall positive findings, no recommendations for corrective action are included in this report. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

As to the OIG's Healthcare Facility Inspection program of VHA medical facilities across the nation, OIG leaders are aware of the ongoing transformation to VHA's management structure that could affect future areas of oversight. The OIG will monitor VHA's change management and maintain its focus on risks to the effectiveness and efficiency of VA programs, operations, and services that can affect the health and welfare of veterans and their families.

[37] "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.

Appendix A: Methodology

The OIG team reviewed facility policies and standard operating procedures, administrative and performance measure data, and relevant prior OIG and accreditation survey reports.[38] The OIG administered voluntary questionnaires to all employees through the facility's email distribution lists to gain insight and perspective related to the organizational culture. The team inspected the facility from December 16 through 18, 2025. The OIG interviewed facility leaders and employees to discuss processes, validate findings, and explore reasons for identified problems. Finally, the OIG physically inspected various areas of the medical facility.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[39] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and took full responsibility for the content of the publication. All references are for original source material, not AI-generated content. The inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB) Memorandum M-25-21, *Accelerating Federal Use of AI through Innovation, Governance, and Public Trust.*[40]

Possible limitations on the information collection methods include questionnaire and interview participants' self-selection bias and response bias.[41] The OIG acknowledges potential bias because the facility liaison selected employees who participated in the interviews; the OIG asked for this selection to minimize the impact of the inspection on patient care responsibilities and primary care clinic workflows.

[38] The accreditation reports covered the time frame of April 10, 2024, through July 15, 2025—the most recent available at the time of the inspection.

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

[40] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.

[41] 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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. During site visits, the team refers concerns that are beyond the scope of the inspections to the OIG's hotline management personnel 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.

OIG oversight authority to review the programs and operations of VA medical facilities is established by the Inspector General Act of 1978.[42] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

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

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 6, 2026

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

Subj: Healthcare Facility Inspection of the Bay Pines VA Healthcare System in Florida

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

Chief Integrity and Compliance Officer (10OIC)

I am grateful for the OIG's review and opportunity to demonstrate how we are providing world-class care to our Veterans at the Bay Pines VA Healthcare System. The report reflects the leaders' and staff commitment to the Veteran and to continuous improvement.

For questions, please contact the VISN 8 Quality Management Officer.

(Original signed by:)

David Dunning, MPA
Acting VISN 8 Network Director

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 29, 2026

From: Director, Bay Pines VA Healthcare System (516)

Subj: Healthcare Facility Inspection of the Bay Pines VA Healthcare System in Florida

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

I am appreciative of the OIG's partnership in ensuring world-class care to the Veterans we proudly serve. Additionally, I am proud of the staff and leaders at the Bay Pines VA Healthcare System for an excellent survey.

For questions, please contact the VISN 8 Quality Management Officer.

(Original signed by:)

David J. VanMeter, FACHE, MHA
Medical Center Director/CEO
Bay Pines VA Health Care System

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