US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Spokane Healthcare System in Washington

Healthcare Facility Inspection	24-03417-188	August 7, 2025

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Spokane Healthcare System (facility) from November 4 through 7, 2024.[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. In an interview, executive leaders identified VHA's national budgetary restrictions as a system shock that affected the organization's culture. To address the fiscal year 2024 budget restrictions, executive leaders became more strategic with hiring and met frequently with facility and Veterans Integrated Service Network (VISN) leaders to improve their hiring processes.[2]

Additionally, although not a recent occurrence, leaders stated the facility implemented the new Oracle electronic health record system as part of VA's Electronic Health Record Modernization

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

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

program, which continues to affect facility operations.[3] It was the first VA facility to implement the Oracle system. Through multiple OIG interviews, executive and facility leaders and staff repeatedly discussed concerns related to the system. Facility leaders and staff described several Oracle issues that challenged staff, including its message center; third-party laboratory results; role assignments; primary care workflow, workload, and patient safety concerns; staff burnout; and training, updates, and change requests.

For example, facility leaders and staff stated Oracle's message center confuses staff and could cause errors because it contains the names of all Department of Defense and VA staff who use the system. Staff and patients could inadvertently email the wrong person, resulting in the information not reaching the intended recipient. Also, providers receive a high volume of messages, which may cause fatigue and distraction and result in patient safety issues. Leaders and staff also said third-party laboratory test results need to be entered into Oracle manually and there is no mechanism to notify staff when the results become available. Staff are also assigned multiple roles within the system and must change between roles to conduct their work, which is time consuming.

Regarding primary care, leaders and staff said inefficiencies within the system cause delays in care and other patient safety concerns. Staff reported tasks take three to four times longer to complete with Oracle as compared to the previous electronic health record system, and they must manually track their community care referrals to ensure patients receive the care they need.[4] Staff expressed that they spend much of their time dealing with system issues rather than patient care, which could lead to harm.

Facility leaders expressed concerns about the system causing staff burnout, fatigue, and frustration and said providers have cited the system as a reason for leaving the facility. Primary care leaders have taken several actions to address workload and workflow concerns, such as modifying clinic schedules and creating ways for staff to report system issues.

Leaders and staff also said training on Oracle was less than optimal. Work processes continually change and make simple tasks complex, which causes staff fatigue and frustration. Leaders and staff also reported when one item is fixed within the system, it often breaks something else and causes additional problems. Facility leaders said staff have reported the concerns to Oracle and

[3] "VA's Electronic Health Record Modernization (EHRM) program is managing the transition from VA's current medical record system, Veterans Health Information Systems and Technology Architecture (VistA), to the Federal EHR." "VA EHR Modernization Frequently Asked Questions," Department of Veterans Affairs, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

[4] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

national VHA leaders. The OIG did not make recommendations because a previous recommendation related to concerns with Oracle remains open.[5]

The OIG also reviewed the results of VA's All Employee Survey and found scores had improved across various areas.[6] In an OIG-administered questionnaire, respondents reported feeling empowered to suggest ways to improve their work and comfortable reporting safety concerns and tough issues with leaders. However, they also indicated leaders had not improved their communication and information was infrequent and not useful. Executive leaders emphasized they increased communication channels, held fun activities like an annual picnic, and shared family and pet pictures. Although leaders stated it can be a challenge to understand what types of communication people consider useful, they should explore additional communication options and monitor the effectiveness of any changes.

The OIG also administered questionnaires to gain insight into veterans' experiences at the facility from veterans service organizations and the facility's Patient Advocates.[7] These respondents generally indicated they could provide feedback to leaders about veterans' care, and leaders were responsive to their concerns.

Environment of Care

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

The OIG found the facility had ample parking, a shuttle service, and access to public bus transportation. Inside the facility's well-lit main entrance was a coffee shop, a help desk, and a volunteer-run ambassador desk with individuals available to assist veterans as needed.

After physically inspecting various patient care areas, the OIG found the facility to be generally compliant with requirements for staff inspecting medical equipment, storing medications, identifying biohazard waste, and restricting access to supply rooms. However, the OIG also

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[5] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022.

[6] 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.

[7] 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/. Veterans service organizations are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families. Edward R. Reese Jr., "Understanding Veterans Service Organizations Roles" (PowerPoint presentation, November 19, 2008), https://www.va.gov/gulfwaradvisorycommittee/docs/VSO.pdf.

noted expired supplies, clean items stored in a soiled utility area, potentially contaminated items stored in a clean storage area, and expired food in soiled containers. The OIG made a recommendation.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The facility had processes to communicate abnormal test results to ordering providers and patients. The Chief of Staff and quality management staff stated two performance measure coordinators review test result communication data quarterly and did not identify any major concerns. However, they identified patient safety concerns with the Oracle system alerting providers of third-party laboratory results and reported the concerns to Oracle and national VHA leaders, as described in the Culture domain above.

The OIG also examined reports, surveys, and reviews involving the facility for the past three years and did not find any recommendations related to test result communication. The OIG noted the facility had one open recommendation from a prior OIG report. The recommendation was to the Deputy Secretary to ensure the electronic health record modernization deployment schedule reflects resolution of the allegations and concerns discussed in that report.[8] Staff said quality management staff monitor actions and outcomes related to oversight reports, and service leaders ensure staff sustain improvements.

Staff explained they identify opportunities for process improvement by reviewing VHA's patient safety reporting system to help identify repeat issues and completing proactive risk assessments. They also plan to use patient safety forums to educate staff and share policy and process changes and lessons learned from their reviews. Although staff were unable to provide an example, they said executive leaders prioritize patient safety and support process improvement projects.

Primary Care

The OIG determined whether primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act affected the primary care delivery structure and new patient appointment wait times.[9] The OIG found the facility experienced an increase in eligibility but did not have additional patient enrollments following the PACT Act.

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[8] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington.*

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

Facility leaders and primary care staff identified shortages of primary care providers, nurses, administrative associates, and social workers. Primary care staff stated the shortages increased clinic workload and appointment wait times and delayed care. Although leaders reported a vacant position, the social workers said they can manage the workload. Leaders also eliminated 36 administrative associate positions due to budget constraints and staffing restrictions. However, VISN leaders recently approved hiring 14 associates.

Leaders acknowledge challenges in hiring providers, social workers, and administrative associates, as well as retaining providers in primary care positions. Leaders reported having eight vacant provider positions in 2024; six providers have since started, and the other two providers were scheduled to start in December 2024.

Staff considered panel sizes (the number of patients assigned to a primary care team) unreasonable since the implementation of Oracle. Additional factors, such as managing complex patients, tracking referrals, and coordinating with specialty and community providers, added to the primary care staff's workload. Leaders worked with Oracle and VISN leaders to address the issues, but the problems persist.

Veteran-Centered Safety Net

The OIG reviewed the Health Care for Homeless Veterans, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing programs to determine how staff identify and enroll veterans and to assess how well the programs meet veterans' needs. The OIG found the facility had active programs with a strong emphasis on outreach services and connections with multiple community partners. The programs provide or refer veterans to a variety of services, including primary care, mental health counseling, employment, and housing services. In addition, staff for the Health Care for Homeless Veterans program said the homeless clinic has a representative from the Veterans Benefits Administration available monthly to meet with veterans about their VA benefits.

Across the programs, staff identified two barriers in meeting veterans' needs: lack of affordable housing and limited transportation. Health Care for Homeless Veterans program staff identified the facility's dress code as another barrier to engaging homeless veterans because they meet them in places like shelters and jails. The OIG requests the Director revise the dress code for homeless program staff.

In addition, although the Housing and Urban Development–Veterans Affairs Supportive Housing program has grown due to a significant increase in the number of assigned housing vouchers, there has not been an increase in staffing. Program leaders continue to advocate with executive leaders for additional staffing to support the workload. The OIG requests the Director review the program's staffing needs and take action, as needed. Veterans Justice Program staff said they were recently notified they could hire another coordinator due to program growth.

What the OIG Recommended

The OIG made one recommendation.

1. The Medical Center Director ensures staff store clean and soiled utility items separately, maintain cleanliness, and dispose of expired items.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the recommendation and provided an acceptable action plan (see appendixes C and D and the response within the body of the report for the full text of the directors' comments). The OIG will follow up on the planned actions for the open recommendation until they are completed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Spokane Healthcare System
Spokane, Washington
Level 2-Medium Complexity
Spokane County
Hospital Referral Region: Spokane

Description of Community

POPULATION

Female **930,705**	Male **939,861**
Veteran Female **14,027**	Veteran Male **121,308**

Homeless - State **25,211**
Homeless Veteran - State **1,569**

MEDIAN INCOME

$56,613

EDUCATION

91% Completed High School
58% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **157**

SUBSTANCE USE

33.0% Driving Deaths Involving Alcohol
18.6% Excessive Drinking
436 Drug Overdose Deaths

UNEMPLOYMENT RATE

5% Unemployed Rate 16+
3% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	609,586
Carpool	80,124
Work at Home	57,602
Walk to Work	28,057
Other Means	14,133
Public Transportation	10,266

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**53 Minutes, 45 Miles**
Specialty Care	**129.5 Minutes, 116 Miles**
Tertiary Care	**278.5 Minutes, 295 Miles**

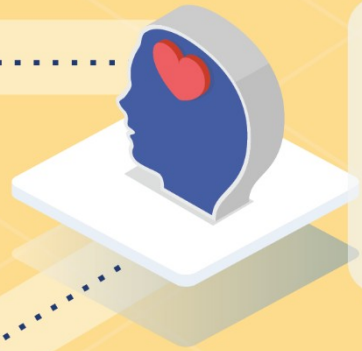
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **7,444**

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	24%
<65 without Health Insurance	16%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

6,642

N/A VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

5.14 Days

30-DAY READMISSION RATE

N/A

SUICIDE RATE PER 100,000

Suicide Rate (state level)	Veteran Suicide Rate (state level)
19	34

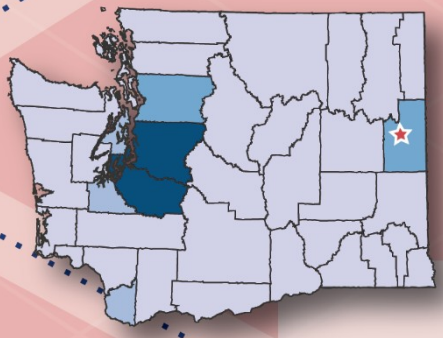
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	38K
Unique Patients VA Care	35K
Unique Patients Non-VA Care	24K

COMMUNITY CARE COSTS

Unique Patient $20,899	Outpatient Visit $622
Line Item $961	Bed Day of Care $342

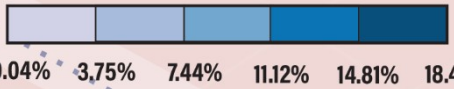


STAFF RETENTION

Onboard Employees Stay <1 Yr	6.92%
Facility Total Loss Rate	14.18%
Facility Retire Rate	2.22%
Facility Quit Rate	10.84%
Facility Termination Rate	1.04%

★ VA MEDICAL CENTER

VETERAN POPULATION



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

Contents

Background and Vision

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

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

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

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

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

High Reliability Organization Framework

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

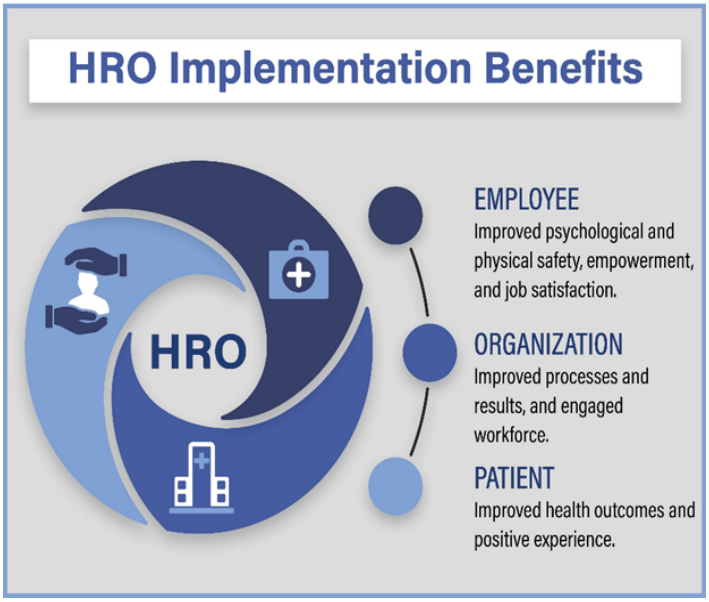


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO

[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.

framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

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; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," 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. *HFI'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(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; 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.

According to facility documentation, the VA Spokane Healthcare System (facility) was constructed in 1948. The facility provides care through the medical center in Spokane, Washington; two community-based outpatient clinics in Coeur d'Alene, Idaho, and Wenatchee, Washington; and two contracted rural health clinics in Libby, Montana, and Sandpoint, Idaho.

At the time of the inspection, the facility's executive leaders consisted of the Medical Center Director (Director), Chief of Staff, Associate Director Patient Care Services, Associate Director, Deputy Chief of Staff, and Deputy Associate Director Patient Care Services. Most of the executive leaders had been working together for a number of years, although the newest member, the Deputy Associate Director Patient Care Services, started in January 2024. In fiscal year (FY) 2024, the medical care budget was $544,770,167, and staff provided care to 37,369 veterans. The facility had 56 operating beds, which included 36 inpatient hospital and 20 community living center beds.[13]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[14] Conversely, skilled and engaged leaders are associated with improvements in quality and patient safety.[15] The OIG examined the facility's culture across multiple dimensions, including unique circumstances and system shocks, leadership communication, and both employees' and veterans' experiences. The OIG administered a facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

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

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

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

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

System Shocks

A system shock is the result of an event that disrupts an organization's usual daily operations. Shocks may result from planned or unplanned events and have lasting effects on organizational focus and culture.[17] An example of a planned system shock is the implementation of a new electronic health record system. An example of an unplanned system shock is a patient suicide on a VHA medical facility campus. By directly addressing system shocks in a transparent manner, leaders can turn both planned and unplanned events into opportunities for continuous process improvement, one of VHA's three HRO pillars.[18]

Figure 4. *New Electronic Health Record System.*
Source: OIG interview.

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 a panel interview, executive leaders discussed several system shocks, including the impact of VHA's budget restrictions.

Leaders stated they were concerned the facility's FY 2024 budget restrictions would limit or delay their ability to fill some positions. Leaders explained they had to restructure how they processed requests to fill vacancies and new positions, which could result in delays. To address the budget challenges, executive leaders reported they became more strategic with hiring and collaborated with facility and Veterans Integrated Service Network (VISN) leaders to improve their hiring processes, such as revising the position request template, implementing office hours to assist supervisors in completing the requests, creating an onboarding tracking system, and meeting weekly to discuss open positions.[19]

Oracle Electronic Health Record System

Leaders emphasized the implementation of the Oracle electronic health record system, as part of VA's Electronic Health Record Modernization program, continues to affect facility operations.[20]

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

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

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

[20] "VA's Electronic Health Record Modernization (EHRM) program is managing the transition from VA's current medical record system, Veterans Health Information Systems and Technology Architecture (VistA), to the Federal EHR." "VA EHR Modernization Frequently Asked Questions," Department of Veterans Affairs, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

Executive and facility leaders and staff repeatedly discussed concerns with the message center; third-party laboratory results; role assignments; primary care workflows, workload, and patient safety concerns; staff burnout; and training, updates, and change requests.

Message center. Facility leaders and staff explained that all orders, results, and other communications go through the Oracle message center, which functions like an email account. Providers can access a patient's electronic health record directly through the message center, and patients using the patient portal can send messages to anyone using Oracle.

Facility leaders and staff reported that despite the many features available through the message center, it created confusion, was complicated and convoluted, and had the potential for causing more errors as compared to the previous electronic health record system. For instance, the message center contains the names of staff at all facilities who use it, including Department of Defense and VA staff. Because of similar names, patients and staff may accidentally send messages to the wrong person. Currently, if a message is sent to the wrong person, the recipient must forward it to the correct person. Users may continue forwarding messages and staff said there was no way to track this process.

The ability to send messages to any staff member using Oracle and the inability to track messages may result in patient safety concerns if messages are lost or unanswered and violate privacy if staff must access patient records to forward messages. In addition, facility leaders and staff said providers receive a high volume of messages, which may cause fatigue and distraction, resulting in patient safety issues.

Third-party laboratory results. Facility leaders and staff stated staff must manually upload noncritical test results from third-party laboratories into Oracle, and once uploaded, Oracle does not alert providers and other clinical staff that results are available. Instead, they must search for the results, which creates additional work. Facility leaders educated providers and clinical staff on this issue and informed them they need to monitor Oracle for the results so they can communicate them to patients, and act on them, as needed. Facility leaders and staff also said they were trying to develop a more standardized way of receiving test results from community providers.

Role assignments. Facility leaders and staff stated that all staff using Oracle had assigned roles, and most staff had multiple roles. There were over 300 at the time of the OIG's inspection; each role shows a different view of the system, and it takes 45 seconds for staff to switch from one to another. Facility leaders and staff explained that when a provider transfers to a different position, they must sign into the message center to both their current and past roles to monitor and respond to messages. Facility leaders and staff stated that VHA leaders were looking for ways to reduce the number of roles.

Primary care workflow, workload, and patient safety concerns. Primary care staff and leaders said the inefficiency caused by Oracle was a detriment to the speed of operations within primary

care. Staff reported tasks took three to four times longer to complete with Oracle as compared to the previous electronic health record system, such as responding to messages and coordinating care for complex patients with multiple medical problems.

Staff also said ineffective Oracle processes cause them to dedicate much of their time to solving issues within the system rather than focusing on health care, which could lead to patient harm. Staff and leaders stated they are committed to providing quality and safe care so they need to be hypervigilant in their work because Oracle lacks necessary checks to ensure patient safety. For example, because Oracle does not track community care referrals, primary care staff said they tally the referrals and routinely check each individually to note where they are in the process.[21]

Staff burnout. Overall, facility leaders and staff expressed concerns about Oracle and considered it a barrier to patient safety and a cause of burnout. Though staff continued to modify work processes to perform daily tasks, leaders said the system made simple work processes more complex and caused staff to be fatigued and frustrated. Leaders also said that during several recent exit interviews, departing providers consistently identified Oracle as a reason they left the facility.

Training, updates, and change requests. Executive leaders stated the initial Oracle training was less than optimal, and it took staff a couple of years to figure out how the system worked. They acknowledged the system was still relatively new and had gone through multiple updates, but this increased workload when staff had to learn new processes. Also, Oracle's notification and education about system updates is not always timely, and sometimes the changes create new problems, all of which frustrate staff and could cause errors. For the above concerns, facility leaders had discussed the concerns, entered tickets for corrections, and shared their concerns with VHA leaders. Facility leaders and staff said approximately 4,000 change requests remain pending with Oracle. The OIG did not make recommendations because a previous recommendation related to concerns with Oracle remains open.[22]

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[23] 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

[21] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed August 9, 2024, https://www.va.gov/communitycare/.

[22] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022.

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

culture.[24] 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."[25]

The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[26] Survey scores for senior leaders in these areas increased between FYs 2022 and 2023; however, they remain lower than VHA averages. During an interview, executive leaders said they were aware of the scores and improving their efforts to ensure frequent and transparent communication with all staff (see figure 5).

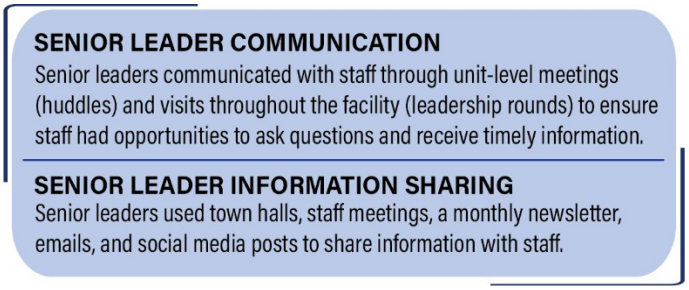


Figure 5. *Leader communication with staff. Source: OIG interview with facility leaders.*

However, in the OIG-administered questionnaire, respondents disagreed that facility leaders changed how they communicate information, and found the information to be infrequent and not useful. When the OIG asked leaders about this inconsistency, they indicated it can be challenging to understand what types of communication people consider useful, so they provide information through multiple channels. The OIG suggests executive leaders explore additional options to improve communication with staff and monitor the effectiveness of any changes.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[27] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[28] The OIG reviewed responses to the

[24] 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*.

[25] 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.

[26] 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.

[27] "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.

[28] 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.

employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

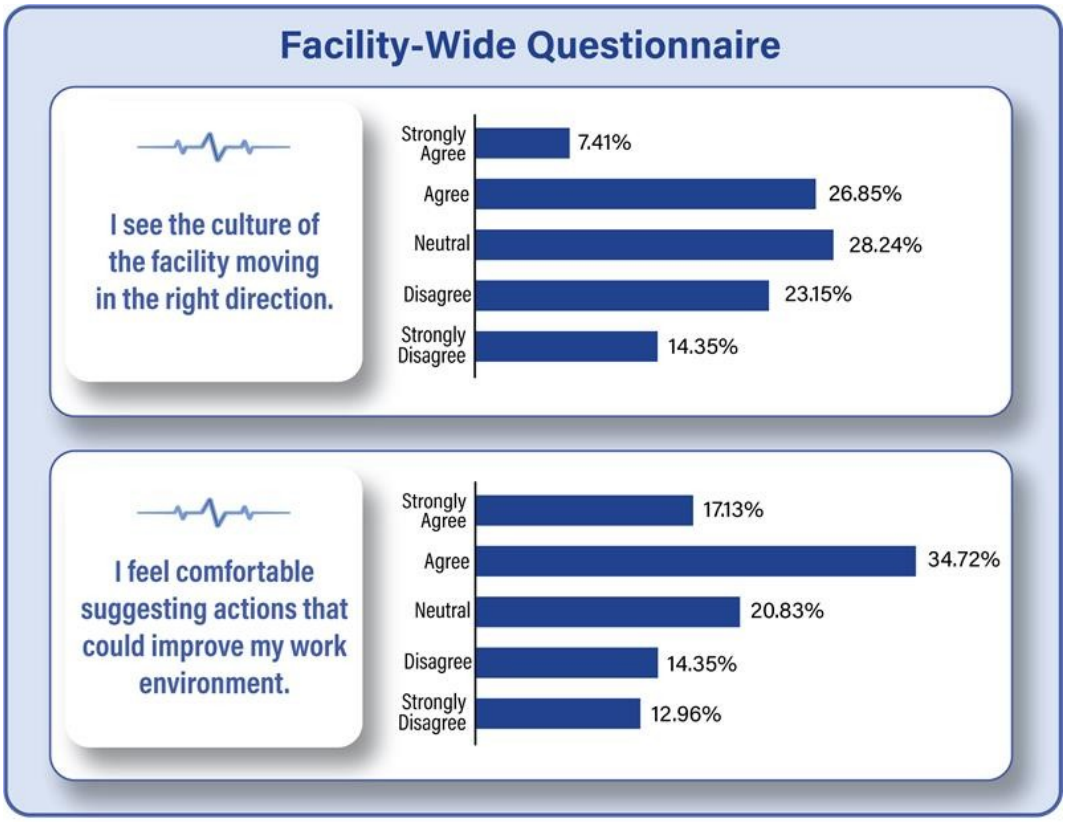


Figure 6. *Employee and leaders' perceptions of facility culture.*
Source: OIG questionnaire responses.

The OIG found the All Employee Survey scores for best places to work, no fear of reprisal, supervisor trust, and psychological safety also increased from FYs 2022 to 2023. During an interview, executive leaders attributed the increased scores to how leaders demonstrated compassion for employees by listening and responding to their concerns. For example, to improve the scores for best places to work, leaders said they engaged with employees through fun activities like holding an annual picnic and sharing family and pet pictures. They also promote VA's Employee Whole Health initiative to ensure employees are happy and healthy.[29]

In the OIG-administered questionnaire, respondents largely indicated they feel empowered to suggest ways to improve the culture of the facility and comfortable reporting patient or staff

[29] VA's Employee Whole Health program supports the well-being of employees by providing them with tools to help them cope with stress, enhancing their resilience and clinical skills, and focusing on their well-being. "Employee Whole Health," Department of Veterans Affairs, accessed June 9, 2025, https://www.va.gov/WholeHealth/professional-resources.

safety concerns and tough issues with leaders. Only about one-third of the respondents indicated they feel the culture is moving in the right direction. In an interview, executive leaders said they increased the frequency of communication and their visibility throughout the organization to engage with staff and build trust.

Veteran Experience

VHA evaluates veteran experience indirectly through patient advocates and VSOs. Patient advocates are employees who receive feedback from veterans and help resolve their concerns.[30] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[31] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In an OIG-administered questionnaire, the patient advocates indicated that facility staff resolved veterans' issues as they arose. An advocate shared an example that demonstrated the Chief of Surgical Services' commitment to veterans; the chief ensures veterans have comment cards in the surgical clinics, collects and responds to patient experience data and comment cards, and looks for ways to improve. The patient advocates indicated that because of the chief's actions, surgical staff managed veterans' complaints more efficiently.

Three VSOs responded to the OIG's questionnaire asking for feedback about working with the facility. The VSO respondents reported they can tell facility leaders about the care veterans receive, and leaders are responsive to veterans' concerns. During a discussion, leaders stated they have a great relationship with the VSOs and meet regularly to inform them about what is occurring at the facility.

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

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

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.[32] 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 7. *Facility photo.*
Source: "Mann-Grandstaff Department of Veterans Affairs Medical Center," Department of Veterans Affairs, accessed October 23, 2024, https://www.va.gov/spokane-health-care/locations/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] 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.[34]

[32] VHA Directive 1608(1).

[33] 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.

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

Transit and Parking

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

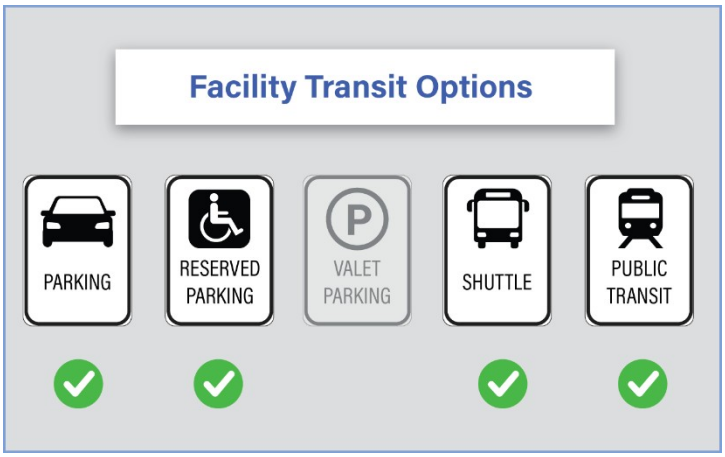


Figure 8. *Transit options for arriving at the facility. Source: OIG analysis of documents, questionnaire responses, and observations.*

The OIG used a commercial navigation application to locate the facility's main entrance. The facility consisted of multiple buildings spread across a large site, and the OIG observed directional signs throughout the area. The parking lots had ample spots, including spaces accessible for those with mobility issues; they were also well lit and had security cameras. Additionally, the OIG observed a shuttle service that circulated between the parking lots, the main entrance, and other buildings to transport veterans to their destinations. Facility staff told the OIG the public bus transit service runs every fifteen minutes during regular business hours.

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.[35]

The OIG noted a passenger loading zone with power-assisted doors and readily available wheelchairs at the main entrance. Once inside the bright main lobby, the OIG observed a coffee shop, a help desk, and a volunteer-run ambassador desk; individuals at both the help and ambassador desks assist veterans as needed. The OIG noted the hallway adjacent to the main entrance is narrow and could cause crowding which makes it difficult for some to get around.

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

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

navigational cues.[36] Although the facility did not have printed maps, help desk staff told the OIG they would direct or escort veterans to their destinations, if needed. The OIG found wall directories and signs hung throughout and used them to successfully navigate around the facility.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] The OIG observed large print signs with high contrast and braille to help veterans with visual impairments.

In the OIG-administered questionnaire, a staff member reported that based on veterans' vision diagnoses, Oracle alerts staff to offer guidance on how best to assist them during their visits. Additionally, the pharmacy offers special medication labels that, when scanned, read the medication aloud. These special labels aid visually impaired veterans in taking their prescribed medications at home.

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of questionnaire responses and observations.

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.[38] Based on responses to the OIG-administered questionnaire, the facility had two toxic exposure screening navigators. However, the role was considered an additional duty.

According to a navigator's response to an OIG-administered questionnaire, staff screen most veterans for toxic exposure during primary care and behavioral health appointments and at the

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

[37] 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.

[38] Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN), October 31, 2022; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

community living center. As of November 7, 2024, the OIG found staff performed approximately 21,267 initial toxic exposure screenings and 12,801 secondary screenings. Additionally, the navigator said they conducted several outreach events over the past 12 months, including a mass mailing to over 3,600 veterans who receive care in the community.

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.[39] 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.

Based on a document review, the OIG did not identify any repeat environment of care inspection findings. The facility met VHA's performance target for closing environment of care deficiencies or creating an action plan to address them within 14 business days, and for an executive leader and core members of the Comprehensive Environment of Care Committee attending environment of care rounds.[40]

General Inspection

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

The OIG physically inspected inpatient, outpatient, and community living center units. The OIG found all examined medical equipment had current inspection stickers; and staff disposed of expired and contaminated medications, identified biohazard waste, and restricted access to supply rooms. The OIG also found the community living center to be inviting for residents and visitors but having a hospital-like environment. Staff told the OIG it was undergoing construction to create single-resident hospice rooms and a more home-like feel.

The OIG found visible protected patient information, a refrigerator door with dirty shelves, and expired food items on multiple units. Staff removed the food items; however, it did not appear they cleaned the containers while the OIG was on site. The OIG also noted a locked dispenser in

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

[40] Acting Assistant Under Secretary for Health for Support, "Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," Memorandum to Veterans Integrated Service (VISN) Directors, May 10, 2024.

a storage room that contained expired supplies; clean items stored in soiled utility areas; and potentially contaminated items kept in clean storage areas, including patient gowns in a ripped bag on the floor. The OIG recommends the Medical Center Director ensures staff store clean and soiled utility items separately, maintain cleanliness, and dispose of expired items.

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

Communication of Urgent, Noncritical Test Results

VHA requires diagnostic providers or designees to communicate test results to ordering providers, or designees, within a time frame that allows the ordering provider to take prompt action when needed.[41] Delayed or inaccurate communication of test results can lead to missed identification of serious conditions and may signal communication breakdowns between diagnostic and ordering provider teams and their patients.[42] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The facility had processes to communicate abnormal test results to ordering providers and patients, assign a proxy (surrogate) when an ordering provider was unavailable or had left the facility, and communicate results outside regular clinic hours. The Chief of Staff and quality management staff said two performance measure coordinators reviewed quarterly reports with test result communication data and discussed them at the Quality and Safety Council meetings. The Chief of Staff and quality management staff did not identify any major concerns; however, the OIG discussed concerns about providers being notified of noncritical third-party test results in the Culture domain above.

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

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

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

hallmarks of an HRO.[43] 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 examined reports, surveys, and reviews involving the facility for the past three years and did not find recommendations related to test result communication. The OIG found one open recommendation from OIG reports issued between July 28, 2021, and July 28, 2024. The OIG noted the recommendation was to the Deputy Secretary to ensure the electronic health record modernization deployment schedule reflects resolution of the allegations and concerns noted in the report.[44]

The Chief of Staff and quality management staff described processes for monitoring action plans and outcomes related to oversight report recommendations. The Accreditation Manager maintains a database of all recommendations and action plans, tracks them until staff resolve the issues, and updates the Quality and Safety Council monthly. The Chief of Quality, Safety, and Value also meets quarterly with quality management staff to ensure staff sustain process improvements. The OIG noted evidence of sustained improvements in documents staff provided.

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.[45] 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.[46] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The Chief of Staff and quality management staff described various methods they use to identify opportunities for improvement, including reviewing VHA's patient safety reporting system entries to help identify repeat issues and completing proactive risk assessments. They said they will incorporate lessons learned and feedback received into the patient safety forums as a way to educate and share information with staff. However, at the time of the inspection, the facility had only one patient safety manager who has been in the position for one year; leaders were in the process of hiring a second patient safety manager.

The Chief of Staff and quality management staff said they meet quarterly after a recommendation is closed to ensure sustainment. However, they identified the volume of

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

[44] VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*.

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

[46] VHA Directive 1050.01(1).

changes made to ensure long-term sustainment is a barrier. For example, every few years VHA adds a new item to implement and monitor, such as toxic exposure screenings.

The Chief of Staff and quality management staff explained that quality management staff had recently initiated listening sessions for staff and leaders. The listening sessions are an opportunity to hear from staff about their concerns. Quality management staff share their concerns with leaders, who then develop action plans to address them. After the listening sessions, quality management staff meet with leaders once a month during the first quarter and then quarterly for the next three quarters to follow up on the action plans.

The goal of the listening sessions and follow-up meetings is to improve the culture and communication between staff and leaders. Staff said the listening sessions are very popular, and leaders asked them to expand this opportunity to other areas. Although staff did not provide a current process improvement project, the Chief of Staff and quality management staff said executive leaders prioritize patient safety and support process improvements, and they did not identify any barriers to initiating such projects.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[47] The OIG also assessed how PACT Act implementation affected the primary care delivery structure. The OIG interviewed staff, analyzed primary care team staffing data, and examined facility enrollment data related to the PACT Act and new patient appointment wait times.

Primary Care Teams

The Association of American Medical Colleges anticipates a national shortage of 21,400 to 55,200 primary care physicians by the year 2033.[48] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages.[49] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

During the OIG site visit, facility leaders and primary care staff identified shortages of primary care providers, registered nurses, licensed practical nurses, social workers, and administrative

[47] VHA Directive 1406(1); VHA Handbook 1101.10(2), *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014, amended February 29, 2024.

[48] Tim Dall et al., *The Complexities of Physician Supply and Demand: Projections from 2018 to 2033* (Washington, DC: Association of American Medical Colleges, June 2020).

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

associates. Staff said these shortages delayed care and increased clinic workload and appointment wait times. Facility leaders acknowledged staffing challenges, especially hiring providers, social workers, and administrative assistants.

Leaders also said retaining primary care providers is challenging and they have offered providers incentives, such as loan repayment, to increase retention. The facility had eight vacant provider positions; leaders and staff stated six providers have started in the primary care service, and two additional providers were scheduled to start in December 2024.

Leaders use float staff to cover some vacancies and absences. However, social workers and administrative associates do not have float coverage. Instead, they work in their assigned clinical area and support other clinical areas that have vacant positions. Leaders reported a vacancy for a social worker in primary care; social workers said they can manage the increased workload at this time. Leaders said they are unable to compete, even with incentives, with private sector salaries for licensed (certified) social workers.

Leaders reported eliminating 36 administrative associate positions due to budget restrictions set by VHA, and the facility had reached its staffing limit. With the staffing shortage, some administrative associates support multiple providers or are assigned additional duties. After repeated requests, VISN leaders approved the request to hire 14 administrative associates.

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.[50] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[51]

Primary care staff considered panel sizes unreasonable given the workload within primary care, staffing shortages, and issues related to the Oracle system. During interviews, staff said facility leaders explained that VISN leaders pushed for larger panel sizes, which led to increased workload for staff and longer appointment wait times for new and established patients.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[52] 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.

[50] "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).

[51] VHA Directive 1406(1).

[52] VHA Handbook 1101.10(2).

The OIG found that despite the challenges with staffing and Oracle, leaders found ways to alleviate some of the burdens primary care staff faced. To assist, leaders

- modified clinic schedules and assessed workflows and processes across primary care and looked for ways in which the teams could support each other and reduce workload;
- created committees and work groups to address issues as they arise and suggest ways to improve the system to Oracle; and
- implemented different avenues for staff to express concerns to leaders, request assistance from colleagues, and share ideas.

Leaders said these actions helped, but problems persist, and they encourage staff to continue reporting all issues related to the system.

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 facility did not experience an increase in veteran enrollment following the PACT Act. In an interview, facility leaders reported an increase in veterans eligible for VA services, but they did not see growth in the number of new patients.

Primary care staff said they provide toxic exposure information to veterans when they check in and ask them to complete a toxic exposure screening tool. The primary care provider enters information from the tool into the electronic health records, then refers veterans for additional services, if needed. Primary care staff explained that toxic exposure screenings were initially burdensome as they learned to integrate them into patient care, but they no longer viewed them as problematic because they developed processes to complete the screenings.

The OIG reviewed the Health Care for Homeless Veterans (HCHV), Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing 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.[53]

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).[54] 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."[55]

The facility exceeded the HCHV5 target in FYs 2022 and 2023 but did not meet it in FY 2024.[56] In an interview, program staff and the Homeless Programs Section Chief attributed missing the target to the closure of a transitional housing program for females and no transitional housing programs outside of Spokane, Washington. As a result, staff are less likely to secure temporary or emergency housing for homeless veterans; veterans use community agencies to access housing instead.

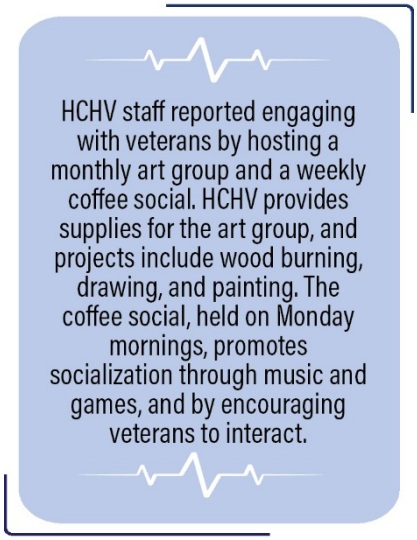


Figure 10. *Program engagement activities.*
Source: OIG analysis of documents and an interview.

Program staff also said they participate in the point-in-time count and events with community partners throughout the service area. However, staff reported the count may not accurately capture the number of homeless individuals because it occurs in January, and veterans are more likely to be sheltered during winter weather. Under these circumstances, the shelter count is more accurate.

In addition to the point-in-time count, staff said they collaborate with community partners to maintain a list of all homeless individuals in the Spokane area. Staff use this list to identify homeless veterans and to assess them for program eligibility and services. Program staff said they then assess the veteran, enroll them into the program, and refer them for VA services, such as medical and mental health care.

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

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

[55] 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.

[56] For the HCHV5 performance measure, the facility reported 105.60 percent for FY 2022, 104.31 percent for FY 2023, and 85.95 percent for FY 2024.

Staff identified the facility's dress code as a perceived barrier to engaging homeless veterans they meet in rural locations, shelters, encampments, and jails. They also expressed concern for their safety if they comply with the dress code because they could be targeted in unsafe locations. The OIG suggests the facility Director revise the dress code for homeless program staff so they may better serve veterans.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[57]

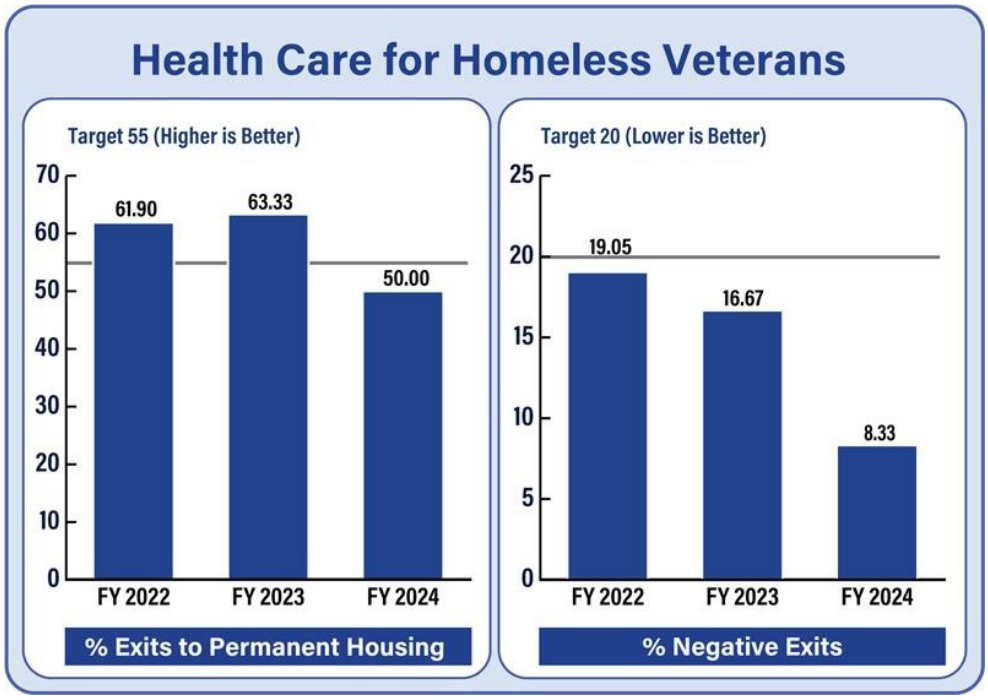


Figure 11. *HCHV program performance metrics.*
Source: VHA Homeless Performance Measures data.

The facility met the HCHV1 target for FYs 2022 and 2023 but did not meet it in FY 2024. In an interview, program staff said the loss of the transitional housing program decreased the number of contracted beds to 10, and any failure to permanently house a veteran after discharge affected

[57] 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*.

them meeting the metric.[58] Staff added the Spokane area has limited housing, which affects the number of veterans who can be discharged to permanent housing.

The program met the HCHV2 target for FYs 2022 through 2024. Staff said they do not have a high turnover rate, and they attributed the low negative exits to the case management services offered. In addition, staff attributed this success to the location of the facility's homeless programs within the homeless clinic. Staff explained that veterans can receive primary care services and mental health counseling, as well as information on accessing the Housing and Urban Development–VA Supportive Housing program at the homeless clinic. There is also a Veterans Benefits Administration counselor available for walk-in appointments at the clinic once a month. This allows veterans to receive multiple VA services in one location.

However, in the OIG-administered questionnaire, the Homeless Programs Section Chief identified a challenge connecting with veterans in rural areas. In response, the program has a dedicated rural outreach worker who establishes connections with community agencies, so the agencies know who to contact if they interact with a veteran. The section chief also said staff use an outreach list and track veterans who are no longer receiving care at the facility to re-engage them in services and discuss housing updates.

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."[59] 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.[60]

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).[61]

[58] VA contracted residential services provides safe living environments for veterans as they transition to other programs or into permanent housing. VHA Directive 1162.04(1), *Health Care for Homeless Veterans Contract Residential Services Program*, February 22, 2022, amended March 7, 2025.

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

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

[61] 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*.

The program did not meet the target for FYs 2022 through 2024.[62] In an interview, program staff and the Homeless Programs Section Chief identified low housing inventory, voucher payments below fair market rent, limited transportation options throughout the large geographic service area, and staffing as barriers to meeting the target.

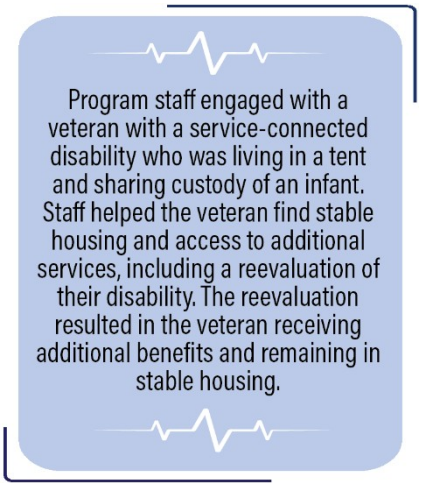


Figure 12. *Program success story. Source: OIG-administered questionnaire.*

To improve performance for this measure, the section chief reported in an OIG-administered questionnaire that staff worked closely with housing agencies, property managers, and landlords to build working relationships and develop housing options. The program's Housing Specialist assists veterans in completing housing applications and obtaining necessary documents. The section chief also noted the program relies on community partners to assist veterans with paying application fees and obtaining photo identification. Program staff explained they provide transportation or donate bus passes to assist veterans as needed.

The section chief reported that in FY 2023, the program received an additional 270 vouchers but no approvals to hire additional staff. At the time of the review, the program had a total of 1,017 vouchers allotted through seven public housing agencies, including two tribally designated housing entities. In response, the section chief briefed facility leaders on the risk of inadequate staffing and advocated for additional hiring to support the workload involved with the additional vouchers. The OIG requests the Director review the program's staffing needs and take action as needed.

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).[63] The program met the target for FYs 2023 and 2024, and the Homeless Programs Section Chief attributed the success to staff working with veterans to help them navigate telework

[62] The facility's HMLS3 scores were 68.31 percent for FY 2022, 71.14 percent for FY 2023, and 65.63 percent for FY 2024.

[63] 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*.

opportunities.[64] Additionally, the program's Employment Specialist assists veterans in finding jobs and refers them to the compensated work therapy program.[65]

Further, the section chief explained that staff are strategically placed throughout the service area to assist veterans who use housing vouchers and receive VA case management services. For example, program staff stationed in Okanogan County serve veterans living in rural northern Washington along the Canadian border. Additionally, staff assess and refer eligible veterans to the Tribal Housing and Urban Development–Veterans Affairs Supportive Housing program, which is the version of the program for enrolled members of federally recognized tribes. One staff member works with the Spokane Tribe and another works with the tribes of the Colville Reservation in Nespelem, Washington.

Program staff also explained they work with an aging veteran population. There are no medical foster homes in Washington, so they developed partnerships with families who are willing to accept housing vouchers and assist with the care of an aging veteran.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[66] 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.[67]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[68] The facility did not meet the target for FY 2023, but did meet it for FY 2024.[69] The Veterans Justice Outreach Coordinator identified performance barriers, such

[64] The facility's VASH3 scores were 46.34 percent for FY 2022, 50 percent for FY 2023, and 53.73 percent for FY 2024.

[65] Compensated work therapy is a VHA recovery-oriented vocational service offered to veterans "who experience occupational difficulties resulting from their mental health, medical disabilities, physical disabilities, or homelessness, or who are unsuccessful at obtaining or maintaining stable community competitive employment." VHA Directive 1163, *Psychosocial Rehabilitation and Recovery Services*, August 13, 2019.

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

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

[68] 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*.

[69] For FY 2023, the facility's target was 25 veterans entering the Veterans Justice Program; however, the facility only reached 48 percent of this target. VHA Homeless Program Office, *Technical Manual: FY 2023 Homeless Performance Measures*. For FY 2024, the facility's target was 25 veterans entering the Veterans Justice Programs and the facility reached 172 percent of their target. VHA Homeless Program Office, *Technical Manual: FY 2024 Homeless Performance Measures*.

as being the only coordinator covering a large service area, lack of timely notifications of veteran incarcerations, and limited access to jails. The coordinator reported staff met with criminal justice staff to negotiate jail access and developed a process to increase referrals. In addition, the coordinator participates in three veterans treatment courts in Washington and one in Idaho.[70] The Homeless Programs Section Chief stated the facility was recently authorized to hire a second coordinator to cover central Washington.

Although the coordinator identified barriers to receiving referrals, an OIG questionnaire respondent indicated that jail staff, public defenders, probation officers, and community members refer veterans to the program. After receiving referrals, the coordinator meets with the veterans, completes the program entry assessments, determines the veterans' initial needs, and refers them for VA or community resources.

The Veterans Justice Outreach Coordinator highlighted the program's commitment to *deflection*, a prevention model that connects health systems and law enforcement, creating a bridge for high-risk veterans to engage in treatment before potential involvement in the criminal justice system. The coordinator set up a web page called First Responder Deflection Support Services, which includes information about VA mental health and substance use disorder treatments, urgent care, intimate partner violence assistance, and resources for homeless and female veterans.* The page is accessible through the facility's internet site or by scanning a QR code printed on business cards the coordinator provides to law enforcement staff.

Figure 13. *First Responder Deflection Support Services.*
** "Police, Treatment, and Community Collaborative," Police, Treatment, and Community Collaborative, accessed June 11, 2025, https://ptaccollaborative.org/.*
Source: OIG analysis of documents and interviews.

Meeting Veteran Needs

Based on facility documentation, the OIG found the coordinator conducted outreach at sheriff departments, conferences, and council meetings and educated police behavioral health units, jail mental health staff, judges, prosecutors, and public defenders about program services. In an interview, the Veterans Justice Outreach Coordinator said program staff may refer veterans to the facility for mental health assessments and treatment, substance use disorder treatment, and therapy groups.

According to the coordinator, some veterans reported being told facility staff do not complete mental health assessments if they are in a court program. The Homeless Programs Section Chief and the Chief of Behavioral Health Service also said staff may be confused regarding the services, but the facility offers mental health and substance use assessments and treatments to all

[70] "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.

eligible veterans. The section and service chiefs agreed to educate the facility's behavioral health staff about the standard operating procedures and services offered to ensure they inform veterans.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. 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 Medical Center Director ensures staff store clean and soiled utility items separately, maintain cleanliness, and dispose of expired items.

__X__ Concur

____ Nonconcur

Target date for completion: February 1, 2026

Director Comments

To enhance oversight, we will conduct weekly audits of clean and soiled utility/storage areas and food pantries. Compliance is determined by the ratio of areas meeting standards (no expired items, no soiled clean areas, no mixing of soiled and clean items) over total monitored areas. Compliance data will be reported by the Accreditation Manager to the Quality and Safety Council, which is chaired by the Medical Center Director and the Chief of Quality, Safety, and Value. Reporting will continue until 90% compliance is achieved for 90 days.

Appendix A: Methodology

Inspection Processes

The OIG inspection team reviewed selected facility policies and standard operating procedures, administrative and performance measure data, VA All Employee Survey results, and relevant prior OIG and accreditation survey reports.[1] The OIG distributed a voluntary questionnaire to employees through the facility's all employee mail group to gain insight and perspective related to the organizational culture. The OIG also created a questionnaire for distribution to 14 VSOs.[2] 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.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] 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.

HFI directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from November 4 through 7, 2024. 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.

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

[2] The OIG received responses from three VSOs (Blinded Veterans Association, American Legion Auxiliary, and American Red Cross). VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/opa/docs/remediation-required/veo/traditionalVeteranOrganizations.pdf.

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

[4] 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.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[5] 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.

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

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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

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. When data are missing from the dataset, the applicable measure is identified as N/A (Not Available).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 14, 2025

From: Network Director, VISN 20 (10N20)

Subj: Healthcare Facility Inspection of the VA Spokane Healthcare System in Washington

To: Director, Office of Healthcare Inspections (54HF02)

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

1. Thank you for the opportunity to provide a response to the findings from the draft report, Healthcare Facility Inspection of the VA Spokane Healthcare System in Washington.
2. I concur with the recommendations and will ensure that corrective actions are completed as described.

(Original signed by:)

Tiel Keltner
Deputy Network Director
VISN 20
For
Teresa D. Boyd, DO

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 2, 2025

From: Director, Mann-Grandstaff VA Medical Center (668)

Subj: Healthcare Facility Inspection of the VA Spokane Healthcare System in Washington

To: Director, VA Northwest Health Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in response to the draft report. I have directed the Chief of Quality, Safety, and Value Service to increase rounding of Infection Preventionists in patient care areas to ensure fidelity to the action plan.

(Original signed by:)

Robert J. Fischer, MD
Medical Center Director

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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.