US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington

Healthcare Facility Inspection	24-00599-202	September 11, 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 Jonathan M. Wainwright Memorial VA Medical Center (facility) in Walla Walla, Washington, from June 4 through 6, 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. Facility staff cited transitioning to the new Oracle electronic health record system in March 2022 and turnover in key leadership positions as system shocks.[2]

The Medical Center Director (Director) described the training provided by Oracle staff as inadequate and said facility staff were not sufficiently prepared to use the new system. Facility staff added that it takes more time for them to complete their work, and when Oracle staff fix an

[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's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR, the Veterans Health Information Systems and Technology Architecture (VistA), with a new commercial EHR solution." "Frequently Asked Questions: What is the Electronic Health Record Modernization Program?," VA EHR Modernization, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/. VA contracted with Oracle to deploy the new electronic health record system. Department of Veterans Affairs, "VA Awards Second Option Period to Oracle Health in Support of Federal Electronic Health Record Modernization Contract," news release, accessed June 24, 2025, https://digital.va.gov/ehr-modernization/news-releases/va-awards-second-option-period-to-oracle-health.

issue, it sometimes leads to another one. Executive leaders actively gathered feedback from staff about the new system and made regular, ongoing training on the system available. Issues related to the Oracle system and leaders' actions to address them are described in detail in the Primary Care section below.

Executive leaders said they used strategies to make employees feel valued, such as holding pop-up karaoke events and having local food trucks on-site. Additionally, the OIG's questionnaire responses showed employees thought facility culture was moving in the right direction and were comfortable suggesting ways to improve their work environment. Leaders said they have an open-door policy and encourage employees to speak to them directly about any concerns. Staff indicated they found leaders' communication clear, useful, and frequent.

Leaders described working with patient advocates and veterans service organization representatives to understand veterans' concerns and taking an active role in resolving the issues.[3] For example, veterans expressed concern about not having supplies to pick up their dogs' waste while on-site, and in response, leaders made waste collection bags available at the facility. The OIG made no recommendations.

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 main entrance clean and well-lit. The OIG noted leaders had moved the sleep and radiology clinics due to construction, but signs were not easily visible, and staff had not updated maps to reflect the new locations. The OIG recommended leaders improve these deficiencies.

The Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act expanded VA health care and benefits to veterans exposed to toxic substances.[4] The OIG reviewed the facility's processes to assist veterans with obtaining screenings under the PACT Act. The toxic exposure screening navigators, who were registered nurses, said they could refer veterans for screenings but could not initiate or complete them in the Oracle system. The system requires a provider, such as physician, to complete these tasks.

[3] Patient advocates 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.

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

Therefore, facility leaders were identifying a provider who would be responsible for the screening process.

The OIG noted executive leaders failed to ensure staff complied with requirements to inspect and test emergency generators and fire doors, which are repeat findings from previous OIG and Joint Commission inspection reports.[5] Although an environment of care leader stated a contract service performs these functions, they were unable to provide documented evidence. The OIG made a related recommendation.

The OIG also found the environment of care committee did not meet as required by VHA.[6] The Associate Director of Operations said the newly hired Safety and Occupational Health Manager would resume the meetings. The OIG recommended improved oversight of the environment of care program.

During a physical inspection of some clinical areas, the OIG found counter surfaces and small appliances covered with debris and food residue, and expired, uncovered, and unlabeled food in the Mental Health Residential Rehabilitation Treatment Program area.[7] The OIG also found a lack of sanitizer refills for hands-free dispensers, and a shelter-in-place emergency supply container with expired food in the Optometry conference room. Expired food could cause foodborne illnesses.[8] Additionally, the facility's emergency management plan did not include information about managing these supplies, as required by The Joint Commission.[9] The OIG recommended leaders correct these deficiencies.

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. VHA required each facility to develop a policy for the communication of test results, and service-level workflows that specify each team members' roles in the process.[10]

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[5] VA OIG, *Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington*, Report No. 19-00053-57, January 8, 2020; The Joint Commission, *Jonathan M. Wainwright Memorial VA Medical Center Final Accreditation Report*, December 9, 2021.

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

[7] The Mental Health Residential Rehabilitation Treatment Program provides substance abuse and mental health services for veterans. VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program,* July 15, 2019.

[8] "Food Poisoning," Mayo Clinic, accessed September 19, 2024, https://www.mayoclinic.org/diseases-conditions/food-poisoning.

[9] The Joint Commission, *Standards Manual*, E-dition, NPSG.07.01.01, August 1, 2024.

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

Although leaders provided a policy, they did not provide service-level workflows for each service. Further, quality management staff and leaders did not describe a process for monitoring providers' compliance with communicating test results to patients. The OIG made related recommendations.

VHA requires facility staff to monitor root cause analysis actions to ensure they are completed and sustain improvements.[11] VHA guidance also states staff should complete most root cause analysis actions within one year.[12] The OIG reviewed meeting minutes from fiscal year 2024 quarter one and noted 22 improvement actions from completed root cause analyses had been open longer than one year. Quality management staff said the number of patient safety events increased following implementation of the Oracle system, and as of quarter three, only six actions had been open for more than one year. The OIG made a related recommendation.

In addition, the OIG reviewed 23 patient safety events related to the communication of test results. Staff completed root cause analyses for two separate patient safety events related to potential delays in community providers notifying VA providers of abnormal test results, and implemented improvement actions to address these issues.[13]

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 PACT Act affected primary care delivery structure and new patient appointment wait times.[14]

Primary care teams had 23 vacant positions, and leaders had difficulty filling vacancies because of low VA wages, the high cost of living in the area, and the lengthy hiring process. The OIG determined leaders focused on recruitment and retention of staff, including offering financial incentives, alternate work schedules, and part-time positions.

Additionally, leaders shared challenges with Oracle, such as frequent system malfunctions. They said the changes increased the time it took for providers to document appointments and other tasks. Primary care staff also said that because they needed more time to complete visits, appointment wait times had increased from an average of 42 days in fiscal year 2022, to 78 days in fiscal year 2023, and 87 days in June 2024.

[11] A root cause analysis "is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[12] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, Version 14, March 2024.

[13] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed June 4, 2025, https://www.va.gov/communitycare/.

[14] PACT Act.

Given the difficulties imposed by the new Oracle system, both staff and leaders expressed concerns about being able to meet the demands of increasing veteran enrollments. Executive leaders emphasized that despite escalating concerns to senior leaders at VHA, the Veterans Integrated Service Network, Oracle, congressional representatives, and the VA Deputy Secretary, who visited the facility prior to the June 2024 inspection, there are no solutions to address the issues.[15] The OIG is concerned the facility is experiencing a combination of factors that, if not resolved, may have a negative impact on patient care.

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. Program staff reported connecting with unsheltered veterans through different sources, including the National Call Center for Homeless Veterans, referrals from facility providers, and calls from veterans or their family seeking program information.[16] Staff described challenges with finding veterans affordable housing and landlords willing to rent to them, and discussed working with community partners to address these barriers.

The Housing and Urban Development–Veterans Affairs Supportive Housing program staff demonstrated committed outreach efforts by working with local housing authority and community partners on initiatives to serve more veterans. Staff said they advocated for other housing options, such as assisted nursing, assisted living, or skilled nursing facilities, to address veterans' housing needs.

What the OIG Recommended

The OIG made nine recommendations for improvement.

1. Executive leaders ensure there are clear signs during construction projects, and maps at the main entrance information desk to help veterans navigate the facility.
2. The Medical Center Director ensures contractors inspect and test emergency generators and fire doors as required, and staff report compliance to an environment of care committee.

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

[16] The National Call Center for Homeless Veterans "was established to ensure that homeless Veterans or Veterans at-risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families, VA medical facilities, federal, state and local partners, community agencies, service providers and others in the community." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

3. The Medical Center Director ensures an environment of care committee meets, as required.
4. The Associate Director of Patient Care Services/Nurse Executive ensures nursing staff monitor proper food clean-up, storage, and disposal in the Mental Health Residential Rehabilitation Treatment Program's areas.
5. The Medical Center Director ensures staff refill hands-free sanitizer dispensers throughout the facility.
6. The Medical Center Director ensures the emergency management plan includes guidance for managing shelter-in-place supplies.
7. Executive leaders ensure staff develop service-level workflows for the communication of test results for each service.
8. The Medical Center Director ensures staff implement a process to monitor providers' compliance with communicating abnormal test results to patients.
9. Executive leaders ensure staff complete improvement actions from root cause analyses within one year.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director concurred with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D). Based on information provided, the OIG considers recommendations 3 and 6 closed. For the remaining open recommendations, the OIG will follow up on the planned actions until they are completed.

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

Abbreviations

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

Jonathan M. Wainwright Memorial VA Medical Center
Walla Walla, Washington
Level 3-Low Complexity
Walla Walla County
Hospital Referral Region: Spokane

FACILITY IN CONTEXT

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: 4,423

Veterans Receiving Telehealth (VHA)	41%
Veterans Receiving Telehealth (Facility)	26%
<65 without Health Insurance	16%

Health of the Veteran Population

VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

2,836

N/A VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

N/A

30-DAY READMISSION RATE

N/A

SUICIDE RATE PER 100,000

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

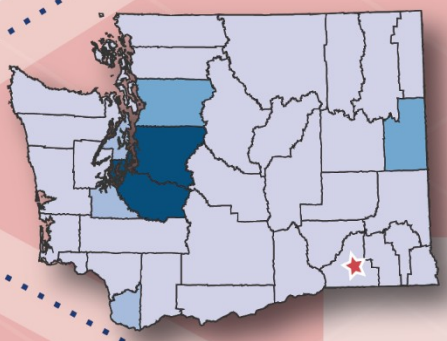
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	21K
Unique Patients VA Care	19K
Unique Patients Non-VA Care	15K

COMMUNITY CARE COSTS

Unique Patient $22,854	Outpatient Visit $1,510
Line Item $1,685	Bed Day of Care $386



STAFF RETENTION

Onboard Employees Stay <1 Yr	7.81%
Facility Total Loss Rate	17.26%
Facility Retire Rate	2.54%
Facility Quit Rate	13.71%
Facility Termination Rate	0.51%

★ VA MEDICAL CENTER

VETERAN POPULATION

0.04% 3.75% 7.44% 11.12% 14.81% 18.49%

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]

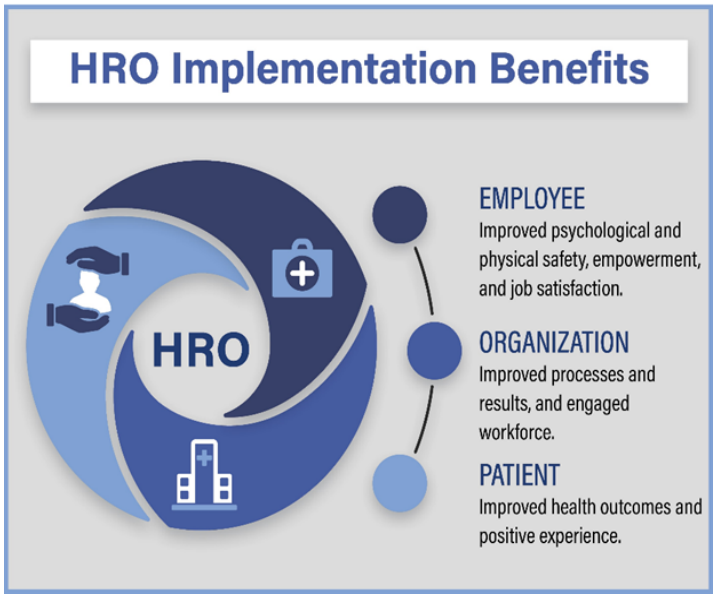


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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 inspectors observed how facility leaders incorporated high reliability principles into their operations.

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[2] Stephanie Veazie, Kim Peterson, and Donald Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles," *Evidence Synthesis Program*, May 2019.

[3] Veazie, Peterson, and Bourne, "Evidence Brief: Implementation of High Reliability Organization Principles."

[4] "PSNet Patient Safety Network, High Reliability," Agency for Healthcare Research and Quality, September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[5] Department of Veterans Affairs, *VHA High Reliability Organization (HRO) Reference Guide*, March 2020, revised in April 2023.

[6] "VHA Journey to High Reliability, Frequently Asked Questions," Department of Veterans Affairs, https://dvagov.sharepoint.com/sites/vhahrojourney/SitePages/FAQ_Home.aspx. (This web page is not publicly accessible.)

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

[8] Stephanie Veazie et al., "Implementing High-Reliability Principles Into Practice: A Rapid Evidence Review," *Journal of Patient Safety* 18, no. 1 (January 2022): e320–e328, https://doi.org/10.1097/pts.0000000000000768.

PACT Act

In August 2022, the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act became law, which expanded VA health care and benefits to veterans exposed to toxic substances.[9] The PACT Act is "perhaps the largest health care and benefit expansion in VA history."[10] As such, it necessitates broad and sustained efforts to help new veteran patients navigate the system and receive the care they need. Following the enactment, VHA leaders distributed operational instructions to medical facilities on how to address this veteran population's needs.[11] As of April 2023, VA had logged over three million toxic exposure screenings; almost 42 percent of those screenings revealed at least one potential exposure.[12] The OIG reviewed how PACT Act implementation may affect facility operations and care delivery.

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

[10] "The PACT Act and Your VA Benefits," Department of Veterans Affairs, accessed April 21, 2023, https://www.va.gov/resources/the-pact-act-and-your-va-benefits/.

[11] Assistant Secretary for Management and Chief Financial Officer (004); Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness (006); Assistant Secretary for the Office of Enterprise Integration (008), "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding (VIEWS 8657844)," memorandum to Undersecretaries, Assistant Secretaries and Other Key Officials, October 21, 2022; Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum to Veterans Integrated Service Network Directors (VISN) (10N1-23), October 31, 2022; Director, VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), November 22, 2022.

[12] "VA PACT Act Performance Dashboard," VA. On May 1, 2023, VA's website contained this information (it has since been removed from their website).

Figure 3. *Healthcare Facility Inspection's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(2), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 10, 2025; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

The OIG evaluates each VHA facility across five content domains: culture, environment of care, patient safety, primary care, and veteran-centered safety net. The evaluations capture facilities' successes and challenges with providing quality care to veterans. The OIG also considered how facility processes in each of these domains incorporated HRO pillars and principles.

The Jonathan M. Wainwright Memorial VA Medical Center (facility) is located on the historic cavalry Fort Walla Walla. In 1921, the Army transferred a portion of the land to VA for a hospital. Initially, the Walla Walla facility operated as a tuberculosis hospital and accepted its first two patients on May 10, 1922. On November 11, 1996, the medical center was renamed to honor Jonathan M. Wainwright IV, a 4-star Army general who commanded US troops in the Philippines during World War II and received the Medal of Honor.

At the time of the inspection in June 2024, the facility's executive leaders consisted of the Medical Center Director (Director), Associate Director for Operations, Chief of Staff, and Associate Director of Patient Care Services/Nurse Executive. The Associate Director of Patient Care Services/Nurse Executive and Director had served on an interim basis in their positions during fiscal year (FY) 2021 and were permanently assigned in January and March 2022, respectively. The Chief of Staff, assigned in July 2023, was the newest member of the team. In FY 2023, the facility's budget was approximately $275 million. The facility had 36 domiciliary beds and served more than 20,000 enrolled veterans.[13]

A 2019 study of struggling VA and non-VA healthcare systems in multiple countries and settings identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[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

[13] A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 11, 2024, https://www.va.gov/homeless/dchv.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.

facility-wide questionnaire, reviewed VA survey scores, interviewed leaders and staff, and reviewed data from patient advocates and veterans service organizations (VSOs).[16]

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] 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] 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.

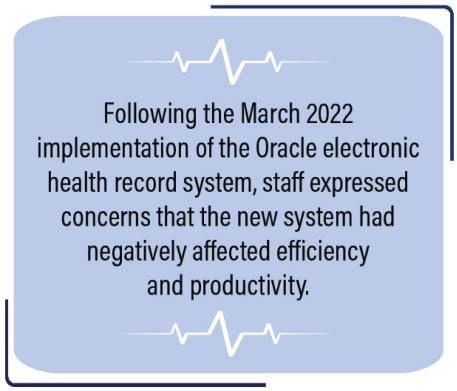

Figure 4. *Facility system shocks. Source: OIG analysis of documents and interviews.*

In an OIG-administered questionnaire, 92 percent of respondents identified implementation of the new VA Electronic Health Record Modernization program in March 2022 as a system shock.[19] Staff explained they need more time to complete tasks compared to the previous system, such as scheduling appointments. Additionally, when staff report system issues, Oracle employees fix the problem; however, this sometimes results in other system issues that cause process inefficiencies.[20] Furthermore, the Director said the training that staff received from Oracle employees did not adequately prepare them for its use.

Executive leaders explained they actively gathered feedback from staff to prioritize concerns about the new system. For example, leaders had staff demonstrate completing tasks so they could discuss the difficulties with Oracle employees. Finally, leaders said they held weekly facility and monthly Veterans Integrated Service Network (VISN)-wide training and offered support to other

[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.

[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's Electronic Health Record Modernization (EHRM) program is an effort to replace the department's current EHR, the Veterans Health Information Systems and Technology Architecture (VistA), with a new commercial EHR solution." "Frequently Asked Questions: What is the Electronic Health Record Modernization Program?," VA EHR Modernization, accessed June 12, 2024, https://digital.va.gov/ehr-modernization/frequently-asked-question/.

[20] VA contracted with Oracle to deploy the new electronic health record system. Department of Veterans Affairs, "VA Awards Second Option Period to Oracle Health in Support of Federal Electronic Health Record Modernization Contract," news release, accessed June 24, 2025, https://digital.va.gov/ehr-modernization/news-releases/va-awards-second-option-period-to-oracle-health.

VHA facilities as they transitioned to the new system.[21] Additional discussion about Oracle implementation and its effects on facility staff and operations can be found in the Primary Care section of this report.

In addition, about 50 percent of questionnaire respondents identified turnover in key leadership positions as a system shock. During an interview with the OIG, executive leaders acknowledged the executive team had experienced recent turnover, and current members had only been permanently assigned within the last two years. The leaders said they built trust among the staff by maintaining transparent communication, addressing their concerns, walking around the facility to be more available, and holding monthly service chief meetings to foster collaboration. Leaders also shared that staff stated they were glad to finally have stable leadership.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[22] Facility leaders can demonstrate dedication to this strategy through "clear and open communication," which helps build trust, signals a commitment to change, and shapes an inquisitive and forthright culture.[23] 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."[24] The OIG reviewed VA's All Employee Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[25]

Respondents to the OIG's questionnaire reported leaders had changed the way they share information and the changes were an improvement, describing leaders' communication as clear, useful, and frequent. Additionally, the facility's VA survey scores for senior leaders' communication and information sharing improved from FY 2022 to FY 2023. During an interview, leaders said they share survey results and their improvement actions with staff. They also regularly communicate with staff through emails, an information board, and one-on-one

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

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

[23] 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*.

[24] 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.

[25] 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.

sessions. Leaders added they have an open-door policy and encourage staff to speak to them directly about any concerns.

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[26] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[27]

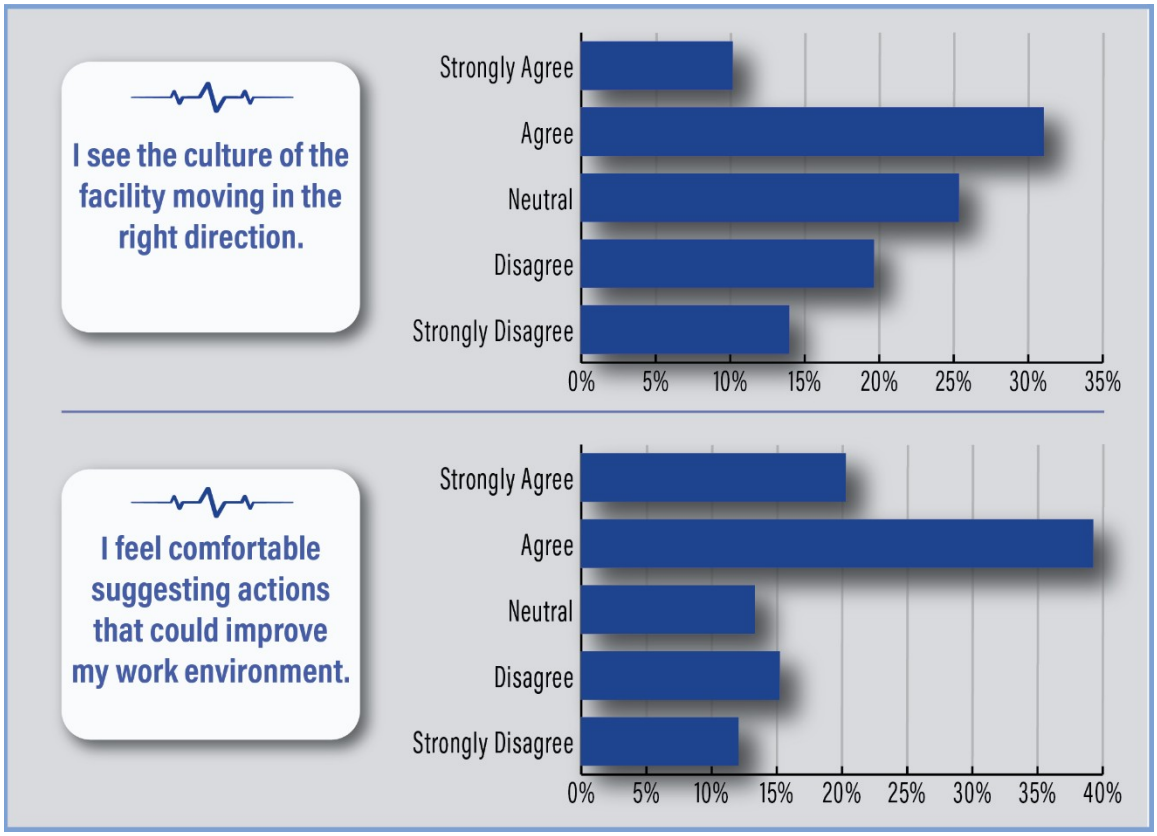

Figure 5. *Employee and leaders' perceptions of facility culture.*
Source: OIG analysis of questionnaire responses.

The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those

[26] "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.

[27] 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.

experiences. The OIG also reviewed survey questions and leaders' interview responses related to psychological safety.

The OIG's questionnaire results showed that, in general, employees perceived the facility culture as moving in the right direction and felt comfortable suggesting actions to improve their work environment. Executive leaders said they show employees they are important and valued by creating fun events, such as pop-up karaoke in the facility's parking lot and paper airplane contests. They also have local food trucks available four days each week.

Leaders also reported hearing a common theme from employees. Employees expressed that in the past, leaders did not always hold everyone accountable for work performance and behavior. As a result, leaders said they increased their efforts to do so, which caused employees to either improve their performance or leave their positions.

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.[28] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[29] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

Based on a patient advocate report, veterans' complaints included receiving medications, scheduling appointments, reaching providers by phone, and receiving community care.[30] However, a substantial number of items in the reports were compliments from veterans. An executive leader said they review patient advocate reports and monitor the percentage of problems resolved weekly.

In addition, executive leaders stated they meet with VSOs to hear about veterans' concerns. Leaders explained they use information from VSOs to change practices at the facility. For example, when they learned that veterans had no way to pick up waste from their support dogs while on-site, they ensured staff provided waste bags. Leaders also said they arranged various subject matter experts to provide VSOs with information and posters to inform veterans about VA services.

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

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

[30] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed June 4, 2025, https://www.va.gov/communitycare/.

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

Figure 6. *The Jonathan M. Wainwright Outpatient Clinic (main entrance) at the Jonathan M. Wainwright Memorial VA Medical Center.*
Source: "Jonathan M. Wainwright Memorial VA Medical Center," Department of Veterans Affairs, accessed October 7, 2024, https://www.va.gov/walla-walla-health-care/locations/.

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[32] 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.[33]

[31] VHA Directive 1608(1).

[32] 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.

[33] 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.

The OIG entered the address listed on the facility's public website into a navigation application and arrived without problems. The OIG observed a public transportation schedule and a city bus stop in front of the facility.

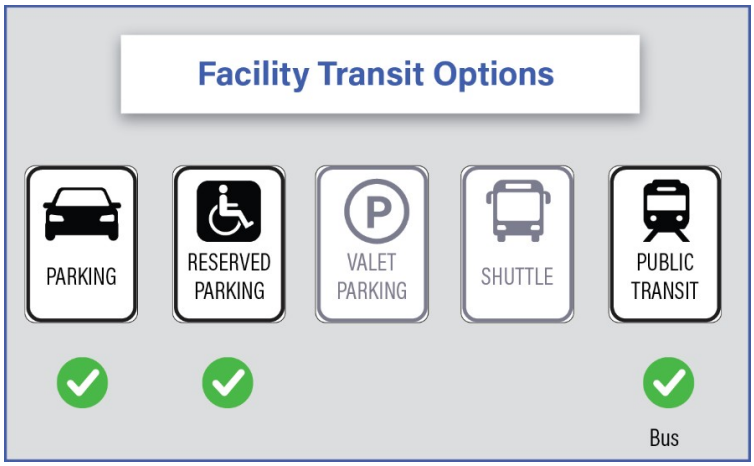

Figure 7. *Transit options for arriving at the facility.*
Source: OIG observations and interviews.

The facility did not offer shuttle or valet services, but had wheelchairs available in the parking lot. The Public Affairs Officer said staff conducted a pilot study to determine the utility of adding shuttle services and found the lack of patient use did not warrant continued efforts. Additionally, VA police highlighted that they patrol the parking lot 24 hours a day and contact other staff to help veterans get to the main entrance.

Main Entrance

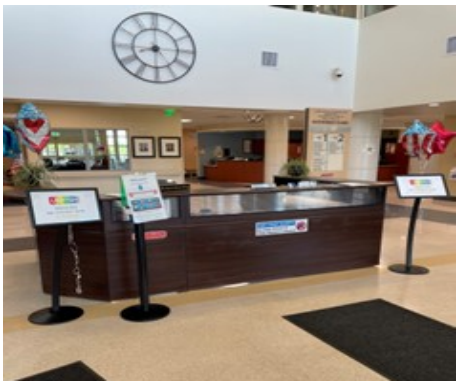

Figure 8. *Main entrance lobby.*
Source: Photo taken by OIG inspector.

The OIG inspected the main entrance to determine whether 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.[34]

The main entrance had a large canopy on the outside to shelter veterans from the weather. It also had power-assisted doors, stairs with access ramps, and wheelchairs available for veterans' use. The main entrance lobby was clean and well-lit with natural lighting and had an information desk in the center. There was also a small seating area near the main entrance and a large, covered courtyard on the second floor that provided veterans a place to socialize.

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

Navigation

Navigational cues can help people find their destinations. The OIG would expect a first-time visitor to easily navigate the facility and campus using existing cues. The OIG determined whether VA followed interior design guidelines and evaluated the effectiveness of the facility's navigational cues.[35]

The OIG found the main entrance's information desk was often unattended, and there was a lack of printed maps to help veterans navigate the facility. The OIG used a free-standing directory (a sign displaying clinic names and room numbers) to successfully find designated locations. During the general physical inspection, the OIG observed a construction project within the Jonathan M. Wainwright Outpatient Clinic. Facility management staff informed the OIG the project required relocating the sleep and radiology clinics. The OIG asked whether maps were available to direct veterans to the new clinic locations, and staff stated they placed temporary signs for the clinics in the parking lot. However, the OIG observed one small sign on a gate, which was not easily visible.

During an interview, the OIG inquired about the lack of printed maps and personnel at the information desk. The Chief, Facility Management Service confirmed that staff had not updated maps to direct veterans to areas affected by the construction project. The Public Affairs Officer explained that one volunteer works at the information desk approximately 20 hours per week.

Without navigation cues or personnel to provide directions, veterans may have trouble finding appointment locations and clinics. The OIG recommends executive leaders ensure there are clear signs during construction projects, and maps at the main entrance information desk to help veterans navigate the facility.

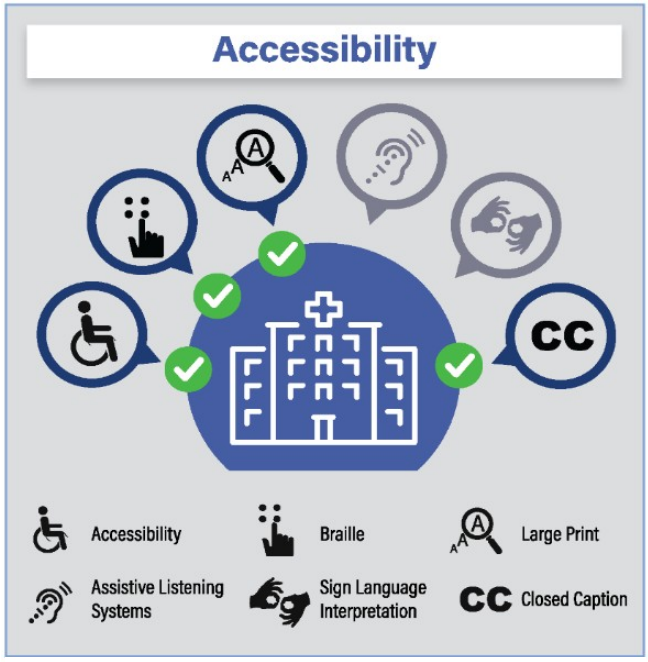

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents.

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

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[36] During the inspection, the OIG observed sound-absorbing ceiling tiles throughout the facility and braille on clinic doors. However, the facility lacked wayfinding applications, such as a kiosk with features for sensory-impaired veterans, and auditory directions, as recommended by VHA interior design guidelines.[37] The OIG also noted closed captioning on some waiting room televisions.

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 based on VA's guidelines.[38] The OIG confirmed the facility had at least two toxic exposure screening navigators. During an interview, the navigators, who are registered nurses, said they can only refer veterans for toxic exposure screenings because only a provider, such as a physician, can initiate and complete the screenings in the new Oracle system.

Prior to the inspection, the OIG reviewed the facility's toxic exposure screening data provided by staff and noted patients waited about five days to be screened. The navigators shared that executive leaders were working to identify a provider who will be responsible for the screening process.

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.

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

[37] VHA Directive 1850.05.

[38] Assistant Under Secretary for Health for Operations (15), "Toxic Exposure Screening Installation and Identification of Facility Navigators," memorandum; VA, *Toxic Exposure Screening Navigator: Roles, Responsibilities, and Resources*, updated April 2023.

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

During the inspection, staff were unable to provide the OIG with evidence they inspected the emergency generators or tested fire doors, as required.[40] The OIG noted similar findings about generators in the previous OIG FY 2020 comprehensive healthcare inspection report, and similar findings about testing fire doors in the facility's FY 2021 Joint Commission survey.[41] The Joint Commission requires staff to inspect emergency generators every week; test them every month, year, and three years; and document the results and dates completed.[42] The Joint Commission also states that every 12 months, staff must test fire doors and document the results and date completed.[43] Inspecting emergency generators and fire doors helps staff identify and mitigate issues that may cause harm if the items do not operate properly when needed.

During an interview, the Chief, Facility Management Services stated a contract service performs these functions but was unable to provide evidence. The chief further explained they did not have records of the contractor performing the tasks and did not report compliance to the environment of care committee because the committee had not met. The facility's Environment of Care, Fire and Life Safety Management Plan requires the Chief, Facility Management Services to ensure contractors complete the required tests, and staff report the information to the environment of care committee.[44] The OIG recommends the Medical Center Director ensures contractors inspect and test emergency generators and fire doors as required, and staff report compliance to an environment of care committee.

VHA requires the Comprehensive Environment of Care Committee to meet to ensure the environment is safe for patient care and services; a member of the executive leadership team to oversee the committee; and the committee to ensure staff develop and implement action plans to address deficiencies from inspections and track actions until they resolve the deficiencies.[45] The OIG was unable to determine whether the committee met because staff did not provide meeting minutes for review. The Associate Director of Operations said the newly hired Safety and Occupational Health Manager would restart the committee meetings. The OIG recommends the Medical Center Director ensures an environment of care committee meets, as required.[46]

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[40] The Joint Commission, *Standards Manual*, E-dition, EC.02.05.07, August 1, 2024; The Joint Commission, *Standards Manual*, E-dition, EC.02.03.05, March 30, 2025.

[41] VA OIG, *Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington*, Report No. 19-00053-57, January 8, 2020; The Joint Commission, *Jonathan M. Wainwright Memorial VA Medical Center Final Accreditation Report*, December 9, 2021.

[42] The Joint Commission, *Standards Manual*, E-dition, EC.02.05.07, August 1, 2024.

[43] The Joint Commission, *Standards Manual*, E-dition, EC.02.03.05, March 30, 2025.

[44] Jonathan M. Wainwright Memorial VA Medical Center, "Environment of Care, Fire and Life Safety Management Plan," February 2024–February 2025. (This plan is not publicly accessible.)

[45] VHA Directive 1608(1).

[46] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

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 the Mental Health Residential Rehabilitation Treatment Program area and Primary Care, Optometry, Audiology, and Surgical Specialty clinics.[47] In the Mental Health Residential Rehabilitation Treatment Program area, which offers a dayroom for group activities and a kitchen for cooking, the OIG found multiple small appliances and counter surfaces covered with debris and food residue. The OIG also noted expired, uncovered, and unlabeled food items in the residents' refrigerator and freezer. A staff nurse informed the OIG that patients were responsible for cleaning the dayroom and kitchen, along with notifying one another when expired items were identified for disposal. However, the staff nurse provided evidence for how program staff oversee appropriate sanitation.

The OIG noted that hands-free sanitizer dispensers that served multiple clinics were empty. Optometry staff stated the clinic had been without sanitizer refills for over six months, and they resorted to using manually operated sanitizer bottles in exam rooms. The Joint Commission requires hospitals to promote good hand hygiene practices to prevent the spread of infection.[48] The Safety and Occupational Health Manager, who participated in the physical inspection, could not provide a reason why they did not have refills.

In addition, the OIG noted the Optometry conference room had a container labeled as a 40-person shelter-in-place emergency kit, which contained supplies for the dental, optometry, and audiology staff. The container had 40 meals with expiration dates of June 2023. The Safety and Occupational Health Manager stated that processes for managing the supplies were included in the facility's emergency management plan. However, the OIG reviewed the plan and found it did not include related guidance.

The Joint Commission requires that a facility's "emergency operations plan includes written procedures for how the hospital will provide essential needs for its staff, volunteers and patients," including food supplies, "whether they shelter-in-place or evacuate."[49] Consuming expired food may cause foodborne illness.[50] The Associate Director of Operations said staff

[47] The Mental Health Residential Rehabilitation Treatment Program provides services for substance abuse and mental health for veterans. VHA Directive 1162.02, *Mental Health Residential Rehabilitation Treatment Program,* July 15, 2019.

[48] The Joint Commission, *Standards Manual*, E-dition, NPSG.07.01.01, August 1, 2024.

[49] The Joint Commission, *Standards Manual*, E-dition, EM.12.01.01, March 30, 2025.

[50] "Food Poisoning," Mayo Clinic, accessed September 19, 2024, https://www.mayoclinic.org/diseases-conditions/food-poisoning.

intended to dispose of the supplies, adding that leaders want to revise the emergency plan with a more efficient process.

To maintain a safe and clean environment, the OIG recommends

- the Associate Director of Patient Care Services/Nurse Executive ensures nursing staff monitor proper food clean-up, storage, and disposal in the Mental Health Residential Rehabilitation Treatment Program's areas;
- the Medical Center Director ensures staff refill hands-free sanitizer dispensers throughout the facility; and
- the Medical Center Director ensures the emergency management plan includes guidance for managing shelter-in-place supplies.[51]

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.[52] 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.[53] The OIG examined the facility's processes for communicating urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

VHA required facilities to develop a test result communication policy and service-level workflows that describe team member roles in the process.[54] Although leaders provided a policy, they did not provide service-level workflows for each service. The OIG recommends executive

[51] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation as implemented before publication of the report.

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

[53] 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.

[54] VHA Directive 1088(1).

leaders ensure staff develop service-level workflows for the communication of test results for each service.

During interviews, quality management staff and leaders did not describe a process for monitoring providers' compliance with communicating test results to patients. The OIG recommends the Medical Center Director ensures staff implement a process to monitor providers' compliance with communicating abnormal test results to patients.

Action Plan Implementation and Sustainability

Figure 10. *Status of prior OIG recommendations. Source: VA OIG.*

In response to oversight findings and recommendations, VA provides detailed corrective action plans with implementation dates to the OIG. The OIG expects leaders' actions to be timely, address the intent of the recommendation, and generate sustained improvement, which are hallmarks of an HRO.[55]

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 found no findings related to communicating test results.[56]

VHA requires the facility director to make sure patient safety managers monitor root cause analysis improvement actions and outcomes until staff complete and sustain actions.[57] The Patient Safety Manager described tracking all actions until staff completed them, meeting with process owners, and reporting results to executive leaders.

The OIG reviewed the Quality and Safety Council meeting minutes for FY 2024, quarter one, and noted 22 root cause analysis actions had been open longer than one year. VHA guidance states staff should complete most root cause analysis improvement actions within one year.[58] When staff do not complete improvement actions timely, they may miss the opportunity to mitigate future occurrences of the safety events.

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

[56] VA OIG, *Comprehensive Healthcare Inspection of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington*; The Joint Commission, *Final Accreditation Report, Jonathan M. Wainwright Memorial VA Medical Center*, December 9, 2021; The Joint Commission, *Final Accreditation Report, Jonathan M. Wainwright Memorial VA Medical Center - Laboratory*, August 8, 2023.

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

[58] VHA National Center for Patient Safety, *Guide to Performing Root Cause Analysis*, Version 14, March 2024.

The Patient Safety Manager said the number of reported patient safety events and subsequent actions had increased substantially following implementation of the Oracle system. The manager added that there were only six actions open for more than one year as of quarter three of FY 2024. The OIG recommends executive leaders ensure staff complete improvement actions from root cause analyses within one year.

The Systems Redesign Manager described tracking all process improvement actions using a similar process the Patient Safety Manager described above.[59] Additionally, the manager reported routinely conducting an audit six months after completing any improvement project to ensure staff sustained project goals. The OIG noted facility staff had completed one improvement project within the past 12 months to improve the community care referral process, which is discussed in the Primary Care section below.

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.[60] 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.[61] The OIG examined the facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

Quality management and systems redesign staff said employees receive training and feedback related to process improvement initiatives and changes. They explained that training may occur via emails and internal website postings, during patient safety forums, or through reports to their workgroups by staff who participated in the initiative.

Prior to the inspection, staff provided the OIG with a list of 23 patient safety events related to test result communication and noted recurring issues with community care providers not notifying VA providers of patients' abnormal test results. One event involved a potential delay in receiving timely follow-up care after a diagnostic test. A different patient experienced a potential delay in having a follow-up radiology test. Staff completed a root cause analysis for both events and implemented improvement actions to address the community care issues.

Staff discovered patients sometimes had delayed or missed radiology examinations due to laboratory test results not being completed or available the day of the exam. In one case, a patient traveled to the facility for a type of x-ray that requires a specific laboratory result to be

[59] "Systems Redesign and Improvement is the VHA practice of utilizing improvement tools to conduct Continuous Process Improvement." VHA Directive 1026.01, *VHA Systems Redesign and Improvement Program*, December 12, 2019.

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

[61] VHA Directive 1050.01(1).

available prior to the x-ray. The patient had the laboratory test performed and waited several hours for the results before deciding to leave without having the x-ray. To prevent this from happening again, leaders established a workgroup to improve how radiology and laboratory staff compare their schedules to identify veterans requiring these tests so they can get their laboratory results quicker and decrease their wait time.

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders.[62] 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.[63] The OIG analyzed VHA staffing and identified primary care medical officers as one of the positions affected by severe occupational staffing shortages in FY 2023.[64] The OIG examined how proficiently the Primary Care Service operated to meet the healthcare needs of enrolled veterans.

During an interview, primary care staff said some staff left their positions because of the difficulties the new Oracle system introduced into their work. For example, staff said it took longer for them to document patient visits and refer them for additional care.

The OIG reviewed documents related to primary care staffing and found the facility had 23 vacant positions (three physician, one physician assistant, eight registered nurse, four licensed practical nurse, and seven support staff positions). Primary care leaders said low VA wages compared to pay in the community, the length of time it takes to hire candidates, and the high cost of living in the local area were all barriers to filling the positions. As a result, leaders stated they receive very few applicants for job listings.

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

[63] 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).

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

Leaders also said they restructured support staff members' roles so they could assist multiple teams and had providers from the VISN's Clinical Resource Hub cover vacancies.[65] Leaders also held hiring fairs at colleges and nearby towns; offered financial incentives, alternate work schedules, and part-time positions; and had a nurse recruiter search for potential candidates.

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.[66] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[67]

Primary care leaders reported that providers' daily appointments decreased from about 12 to 8 to accommodate education and training during implementation of the new Oracle system. Post implementation, leaders indicated providers still see fewer patients than in the past due to the increased time it takes to complete tasks and system workflows not working properly, which requires frequent assistance from Oracle employees. The OIG reviewed data provided by facility staff that showed new and established patient appointment wait times had increased from an average of 42 days in FY 2022, to 78 days in FY 2023, and 87 days in June 2024. Staff said wait times increased because of the time needed to complete visits using Oracle.

Executive leaders reported escalating concerns related to the Oracle system to senior leaders at VHA, the VISN, and Oracle. Primary care leaders stated that congressional representatives and the VA Deputy Secretary have visited the facility to hear their concerns about the system, but no one has found any solutions to address the problems.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[68] 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.

Primary care staff informed the OIG that each primary care team determines the focus of process improvement projects. Current staff projects to improve care and efficiency focused on addressing difficulties created by the Oracle system related to community care referrals. For example, staff shared that leaders and providers were concerned about the backlog of referrals

[65] Clinical resource hubs provide "care to Veterans at their local VA health care facilities through telehealth technology or in-person visits." "Patient Care Services, Clinical Resource Hubs (CRH)," Department of Veterans Affairs, accessed June 13, 2024, https://www.patientcare.va.gov/primarycare/CRH.asp.

[66] "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).

[67] VHA Directive 1406(2).

[68] VHA Handbook 1101.10(2).

and the effect on veterans' experiences. As a result, leaders created a new coordinator position and hired eight administrative staff and five registered nurses to help with the referral process. The time between a provider entering a referral in the system and community care staff scheduling the appointment decreased, on average, from 110 days in October 2022 to 7 days in December 2023.

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. Primary care team members stated that the increase in veteran enrollment since implementation of the PACT Act has placed more workload demands on staff. Team members expressed concerns about meeting patient needs with the increasing enrollment, given staffing levels and difficulties imposed by the Oracle system. The OIG is concerned the facility is experiencing a combination of factors that, if not resolved, may have a negative impact on care delivery through even longer appointment wait times. However, the OIG found that executive leaders and staff remained focused on providing quality patient care.

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.[69]

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).[70] VA uses the Department of

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

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

Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[71]

The program did not meet the HCHV5 target from FYs 2021 through 2023.[72] However, the program met the target in the first and second quarters in FY 2024.[73] An HCHV staff member attributed the improved scores to weekly visits to community sites and motivational interviewing skills when completing the assessment. They also told the OIG they identified unsheltered veterans for enrollment through the National Call Center for Homeless Veterans, referrals from facility providers, and calls from veterans or families requesting general information.[74] Additionally, HCHV staff told the OIG they connect with unsheltered veterans at collaborative events with community partners, such as the Salvation Army and Veterans of Foreign Wars.[75]

The facility's HCHV program reported they secured suitable housing that accommodated a veteran's medical needs and service animal through coordination with community partners. This example highlights the importance of collaborative case management and outreach efforts and demonstrates the facility's commitment and support for unsheltered veterans. HCHV staff shared that good communication, listening with understanding, and nonjudgmental support are crucial in helping veterans transition to stable housing.

Figure 11. *Best practice for veteran engagement.*
Source: OIG analysis of documents and interviews.

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

[71] 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.

[72] VHA sets quarterly escalating targets for the HCHV5 metric each FY: quarter one, 25 percent or above; quarter two, 50 percent or above; quarter three 75 percent or above; and quarter four, 100 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures,* October 1, 2022. The facility's HCHV5 performance for FYs 2021, 2022, and 2023 were 58 percent, 53 percent, and 59 percent, respectively.

[73] The facility's HCHV5 performance for the first and second quarters of FY 2024 were 25 percent and 51 percent, respectively.

[74] The National Call Center for Homeless Veterans "was established to ensure that homeless Veterans or Veterans at-risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless Veterans and their families, VA medical facilities, federal, state and local partners, community agencies, service providers and others in the community." VHA Directive 1501, *VHA Homeless Programs*, October 21, 2016.

[75] "The Salvation Army offers a range of veterans services, providing comfort, support, counseling, and a home to thousands of veterans in need each year." "Veteran Services," The Salvation Army, accessed October 24, 2024, https://www.salvationarmyusa.org-serve. "The Veterans of Foreign Wars of the United States is a nonprofit veterans service organization comprised of eligible veterans and military service members from the active, guard and reserve forces." "About Us," Veterans of Foreign Wars, accessed September 24, 2024, https://www.vfw.org/about-us.

the program without consulting staff" (performance measure HCHV2).[76] HCHV staff told the OIG that they do not have metrics for the performance measures because VHA captures data based on transitional residential housing, which the facility does not have.

When asked about meeting veterans' needs, HCHV staff told the OIG it was difficult to find affordable housing and landlords willing to rent to veterans. Staff said some landlords have concerns about rent payment and property damage. They added that some rental agencies may automatically reject applications from veterans with a criminal history, further decreasing housing options.

HCHV staff explained that Supportive Services for Veteran Families providers, along with other community partners, play a vital role in supporting veterans' housing by addressing needs such as rent deposits, application fees, and training programs.[77] Staff shared that these organizations are essential because they can provide immediate assistance and help veterans build on skills that can lead to a sustainable income needed for stable housing. Staff further explained the facility does not offer emergency shelter, and they must rely on community resources, including those designed to help veterans diagnosed with posttraumatic stress disorder, severe medical conditions, or substance use disorders.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[78] Veterans Justice Programs serve veterans at all stages of the criminal justice system, from contact with law enforcement to court settings and reentry into society after incarceration. By facilitating access to VHA care and VA services and benefits, the programs aim to prevent veteran homelessness and support sustained recovery.[79]

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[80] The OIG found that although the program did not meet the overall target for FY 2023, the number of veterans enrolled increased each quarter during the

[76] 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*.

[77] The Supportive Services for Veteran Families "program provides supportive services to very low-income Veteran families in or transitioning to permanent housing." VHA Directive 1501.

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

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

[80] VHA sets escalating targets for this measure at the facility level each year, with the goal to reach 100 percent by the end of the FY. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

FY.[81] A program staff member told the OIG that identifying and reaching all veterans in rural areas was difficult, and they considered their current performance commendable and reflective of their dedication, hard work, and outreach efforts.

Additionally, former program staff had not input veteran enrollment data into the system of record and current staff have focused on ensuring they enter eligible veterans and those already receiving case management. As a result, there is significantly more data for tracking veterans' needs and services. The program staff member reported believing that visiting various locations within their service area, giving presentations, and encouraging local agencies to inquire if clients are veterans also helps identify those who may benefit from program services.

Program staff said they collaborate with various stakeholders, such as first responders, jail staff, crisis centers, courts, probation officers, and lawyers to ensure they identify veterans within the justice system or facing criminal legal issues and connect them with appropriate VA services. Staff explained that during outreach activities, they met with key personnel at courts and jails to educate them on the program and the National Call Center for Homeless Veterans.

While not directly assisting veterans with legal matters, program staff said they advocate for veterans to receive VA support services, such as substance abuse or mental health treatment, employment services, and housing, aiming to address underlying issues that can contribute to legal challenges faced by veterans. Program staff emphasized the importance of building relationships within the community and establishing connections in justice settings, veterans treatment courts, and other community agencies to ensure comprehensive support for veterans involved in the justice system.[82] Staff also told the OIG they had expanded outreach into rural areas to assist veterans who may be isolated and less connected to VA services, addressing issues like seclusion, safety concerns, and mental health challenges.

Meeting Veteran Needs

Program staff told the OIG they track all outreach activities, including the type of outreach conducted, number of individuals reached, time spent, and the nature of the engagement, to quantify efforts and understand the extent of outreach conducted during the year. A staff member also said they are involved in community initiatives aimed at establishing veterans treatment courts, especially for those with mental health and substance abuse issues. Staff also shared that they meet weekly to discuss the overall progress of veterans and reported believing the judge

[81] The facility's consecutive quarterly VJP1 performance measure percentages for FY 2023 were 23 percent, 53 percent, 71 percent, and 92 percent, respectively.

[82] "A Veterans 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.

attorneys valued their input, which emphasized their collaborative approach to supporting veterans effectively.

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."[83] 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.[84]

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).[85] The program did not meet the target in FYs 2021 through 2023. A program staff member explained that unused vouchers previously assigned to other areas were reallocated to Walla Walla. According to the staff member, this reallocation resulted in the facility having more vouchers than needed for the town's small local homeless veteran population, which lowered their percentage.

Staff said program social workers and case managers work collectively to provide housing stability and support services to veterans. The staff also said they distribute flyers, meet with community partners, and help locate and assist homeless veterans. They also advocate for special housing placements, such as assisted nursing, assisted living, or skilled nursing facilities to increase the number of veterans who can participate in the program.

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

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

[85] VHA sets the HMLS3 target at the national level each year. The FY 2023 target for HMLS3 was 90 percent or above. VHA Homeless Programs Office, *Technical Manual: FY 2023 Homeless Performance Measures*.

Meeting Veteran Needs

Figure 12. *Housing on the facility site. Source: Photo taken by OIG inspector.*

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).[86] The program did not meet the target during FY 2021, but did meet it in FYs 2022 and 2023. Program staff said they categorize some veterans as unemployed when they did not seek work due to disability, retirement, enrollment in school, or other reasons. Program staff reported receiving education to clarify what constitutes veterans who are unemployed and not capable of working to ensure they accurately documented veterans' employment status in the system of record that tracks data for the performance measure.

Program staff also told the OIG they worked closely with the housing authority and local agencies that manage Supportive Services for Veteran Families' grants for housing. In addition, staff met regularly with community partners to discuss housing options, coordinate efforts to house veterans, and collaborate with community partners for outreach opportunities, such as soup kitchens, to support veterans. Program staff shared that a unique initiative of the program includes housing on the facility's site, which has led to successful VA employment and treatment outcomes for veterans.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains. The OIG provided recommendations on issues related to navigational signs and maps, environment of care oversight, cleanliness, supplies, test result communication, and root cause analysis improvement actions. 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.

[86] 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*.

OIG Recommendations and VA Responses

Recommendation 1

Executive leaders ensure there are clear signs during construction projects, and maps at the main entrance information desk to help veterans navigate the facility.

_X_ Concur

____ Nonconcur

Target date for completion: January 15, 2026

Director Comments

Temporary wayfinding signs and map availability for Veterans have been added to the Construction inspection audit checklist which is completed weekly when a construction project is in process. There are currently no construction projects in process.

Maps are available at the main entrance information desk in Building 143 and beginning in July 2025, are verified via weekly audit by the Veterans Experience Office.

Compliance data will be reported by the Veterans Experience Officer quarterly to the Environment of Care Committee, chaired by the Associate Director of Operations, until compliance has been sustained at 90% or greater for six consecutive months.

The numerator will be defined as the total number of observations in which maps are available. The denominator will be defined as the total number of observations.

Recommendation 2

The Medical Center Director ensures contractors inspect and test emergency generators and fire doors as required, and staff report compliance to an environment of care committee.

_X_ Concur

____ Nonconcur

Target date for completion: February 28, 2026

Director Comments

Fire door and emergency generator testing is maintained and stored on a shared drive.

Facility staff inspect and test emergency generators monthly. Additionally, annual and triennial emergency generator testing and fire door inspections are completed by contracted, qualified vendors.

Compliance data about these testing events will be communicated semi-annually by the Safety and Occupational Health Manager to the Environment of Care Committee, chaired by the Associate Director of Operations, until compliance has been sustained at 90% or greater for six consecutive months.

The numerator will be defined as the number of completed, compliant tests and the denominator will be defined as the total number of required tests.

Recommendation 3

The Medical Center Director ensures an environment of care committee meets, as required.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The Safety and Health Leadership Committee was changed to the Environment of Care Committee in May 2024. The Environment of Care Committee was chartered and has continued to meet monthly.

OIG Comments

The OIG considers this recommendation closed.

Recommendation 4

The Associate Director of Patient Care Services/Nurse Executive ensures nursing staff monitor proper food clean-up, storage, and disposal in the Mental Health Residential Rehabilitation Treatment Program's areas.

_X_ Concur

____ Nonconcur

Target date for completion: January 15, 2026

Director Comments

Nursing staff will provide oversight of food clean-up, storage and disposal by performing checks of the Mental Health Residential Rehabilitation Treatment Program areas three times per day. A line item was added to the daily shift rounding checklist.

Updates to the checklist were reviewed with staff and current residents on July 14, 2025. New nurses are trained to the requirements during unit specific nurse orientation. New residents are

provided with this information in two ways: The Residential Rehabilitation Unit morning community meeting and the mandatory unit orientation Power Point presentation.

The Residential Rehabilitation Unit Nurse Manager will track compliance and report data to the Mental Health Executive Committee quarterly until compliance is demonstrated at 90% or greater for six consecutive months.

The numerator will be defined as the number of observations in which the areas are clean and free of improperly stored or labeled food. The denominator will be defined as the total number of observations.

Recommendation 5

The Medical Center Director ensures staff refill hands-free sanitizer dispensers throughout the facility.

_X_ Concur

____ Nonconcur

Target date for completion: February 15, 2026

Director Comments

The Environmental Management Services Chief conducted a facility-wide assessment of all hands-free sanitizer dispensers in August 2024. The facility was found to have adequate hands-free dispensers and sanitizer in place.

In July 2025, the Environmental Management Services Chief implemented weekly rounds to verify the expiration dates and refill levels of sanitizer.

The Environmental Management Services Chief will report compliance data to the Environment of Care Committee monthly until compliance is demonstrated at 90% or greater for six consecutive months.

The numerator will be defined as the number of dispensers containing hands-free sanitizer, and the denominator will be the total number of dispensers.

Recommendation 6

The Medical Center Director ensures the emergency management plan includes guidance for managing shelter-in-place supplies.

_X_ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The container labeled as a 40-person shelter-in-place kit, which had expired items, was removed at the time of inspection. As of December 2024, all shelter-in-place kits were removed from Walla Walla VAMC locations. The included Emergency Management plan was updated, and guidance regarding shelter-in-place supplies was removed.

OIG Comments

Because staff removed all shelter-in-place kits, the plan no longer requires guidance on managing these supplies. The OIG considers this recommendation closed.

Recommendation 7

Executive leaders ensure staff develop service-level workflows for the communication of test results for each service.

_X_ Concur

____ Nonconcur

Target date for completion: October 31, 2025

Director Comments

The existing Standard Operating Procedure "Communicating Test Results to Providers and Patients" was revised and signed on July 31, 2025, and ensures provider service-level workflows for the communication of test results for each service.

The Associate Director of Patient Care Services and Chief of Staff will revise the Standard Operating Procedure to include the addition and participation of other members of the patient's health care team to facilitate processes related to communication of test results by October 31, 2025. The revision will include following the robust principles of teamwork, including clarifying task delegation, roles of team members, key responsibilities on test result related actions and contingency planning.

Recommendation 8

The Medical Center Director ensures staff implement a process to monitor providers' compliance with communicating abnormal test results to patients.

_X_ Concur

____ Nonconcur

Target date for completion: February 27, 2026

Director Comments

The existing Standard Operating Procedure Communicating Test Results to Providers and Patients was revised and signed on July 31, 2025, and outlines a process for compliance with communicating abnormal test results to patients.

Starting in August 2025, the Chief of Staff will assign 30 random charts for monthly auditing to the Service Chiefs of the following services: Primary Care Walla Walla, Richland Community Based Outpatient Clinic, Lewiston Community Based Outpatient Clinic, LaGrande Community Based Outpatient Clinic, Yakima Community Based Outpatient Clinic, Mental Health, Dental, Optometry, Anticoagulation, Home Based Primary Care, and Specialty Services.

The Chief of Staff will report the results monthly to the Quality and Patient Safety Council until compliance is demonstrated at 90% or greater for six consecutive months.

The numerator will be defined as the number of compliant charts, and the denominator will be the number of charts audited.

Recommendation 9

Executive leaders ensure staff complete improvement actions from root cause analyses within one year.

_X_ Concur

____ Nonconcur

Target date for completion: February 27, 2026

Director Comments

Beginning in August 2025, bi-weekly meetings between the Patient Safety Manager and Executive Leadership were established to evaluate root cause analysis action items approaching their targeted implementation dates.

The Patient Safety Manager will report data to the Quality and Patient Safety Council monthly until 100% compliance is reached for six consecutive months. The Quality and Patient Safety Council reports to the Executive Leadership Board.

Compliance will be 100% of root cause analysis action items completed within one year of the implementation date defined in the root cause analysis.

The numerator will be defined as the total number of action items closed within one year of the implementation date defined in the root cause analysis and the denominator will be defined as the total number of action items.

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 one VSO.[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.

Healthcare Facility Inspection directors selected inspection sites and OIG leaders approved them. The OIG physically inspected the facility from June 4 through 6, 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, 2020, through September 30, 2023.

[2] The OIG submitted a questionnaire to one VSO (Vietnam Veterans of America) based on VA's statement that "VA works most closely with [these organizations]." VA, "Traditional Veterans Service Organizations" (fact sheet), accessed May 23, 2023, https://www.va.gov/opa/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 23, 2025

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

Subj: Healthcare Facility Inspection of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington

To: Director, Office of Healthcare Inspections (54HF05)

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 Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, 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 16, 2025

From: Director, Jonathan M. Wainwright Memorial VA Medical Center (687)

Subj: Healthcare Facility Inspection of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla, Washington

To: Director, VA Northwest Network (10N20)

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Healthcare Facility Inspection of the Jonathan M. Wainwright Memorial VA Medical Center in Walla Walla.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in responses to the draft report.

(Original signed by:)

April L. Hughes, MSHA-QA, BSN, RN
Associate Director for Patient Care Services Nurse Executive
Jonathan M. Wainwright Memorial VAMC
for
Scott D. Kelter
Medical Center Director

OIG Contact and Staff Acknowledgments

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