US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Healthcare Facility Inspection of the VA Puget Sound Health Care System in Seattle, Washington

Healthcare Facility Inspection	**24-00612-119**	**June 3, 2025**

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Executive Summary

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

What the OIG Found

The OIG physically inspected the VA Puget Sound Health Care System (facility) from July 29 through August 1, 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. Executive leaders identified the COVID-19 pandemic and the new Electronic Health Record Modernization program as system shocks that affected the organization's culture.[2] Leaders discussed the pandemic beginning in Washington state and caring for the first veteran patient. They acknowledged needing to adjust how they provided care during the pandemic and described the pandemic as a catalyst for change.

The facility was initially scheduled to be the first large, complex facility to implement the new Oracle Cerner electronic health record system under the Electronic Health Record Modernization program; however, due to the complexity of services offered at the facility, VHA leaders delayed implementation. Leaders conveyed that system shocks usually have an end point; but patients

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

continue to be admitted with COVID-19, and the new electronic health record system still needs to be implemented.

The OIG found that All Employee Survey scores had improved across various areas, including communication and information sharing, best places to work, supervisory trust, and psychological safety, but were below VHA averages.[3] Based on the OIG-administered questionnaire, staff indicated that leaders improved their communication, the information was clear, and they felt empowered to suggest further improvement.

A veterans service organization and most of the facility's patient advocates reported they and the veterans could provide feedback to leaders about veterans' care.[4] Leaders hold town hall meetings to share information with veterans, and an advisory committee provides feedback and ideas to facility leaders.

Leaders addressed veterans' most common complaints, which were about community care billing and delays with pharmacy deliveries.[5] Leaders stated they identified a point of contact for community care, who has since addressed all but one billing concern. Leaders also added three nurses to the Patient Advocate Office to help veterans with complex needs. They highlighted that veterans' complaints have decreased since these changes. For pharmacy deliveries, leaders said they explained to veterans that they are unable to control the postal service delivery schedule.

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 clinical and nonclinical areas inspected to be clean, and the facility had ample parking and a welcoming main entrance. Most signage in the facility was up to date, and staff had requested new signs for areas currently being relocated. Facility leaders and staff

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

[4] 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. Patient advocates are employees who receive feedback from veterans and help resolve their concerns. "Veterans Health Administration, Patient Advocate," Department of Veterans Affairs, accessed May 9, 2023, https://www.va.gov/HEALTH/patientadvocate/.

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

identified floor maintenance (stripping, waxing, and polishing) as a chronic problem. Leaders had purchased new floor cleaning and maintenance equipment and initiated a contract for additional housekeeping services.

Patient Safety

The OIG assessed vulnerabilities in communication procedures for urgent, noncritical abnormal test results; the sustainability of changes made by leaders in response to previous oversight recommendations; and implementation of continuous learning processes to identify opportunities for improvement. The OIG found the facility had policies and processes for communicating test results and conducted internal audits of individual providers to monitor compliance related to the communication of test results.

Facility staff described a process improvement project they implemented following a patient's death. A patient presented to the facility's emergency department with symptoms of a myocardial infarction (heart attack) and needed a cardiac catheterization (medical procedure used to diagnose and treat heart conditions). The facility did not offer the procedure, and there was difficulty finding a local hospital to accept the patient; the patient died. To prevent delays, staff developed a process improvement project in which they formalized a memorandum of understanding with a local hospital and an informal agreement with another hospital to transfer patients. Staff tracked data on this project and said they transferred 33 patients to a local hospital, with one reported death. Staff stated they presented this project at VHA's annual patient safety conference in June 2024.

Primary Care

The OIG determined whether facilities' primary care teams were staffed per VHA guidelines and received support from leaders. The OIG also assessed how the Sergeant First Class Heath Robinson Honoring Our Promise to Address Comprehensive Toxics (PACT) Act implementation affected the primary care delivery structure and examined facility enrollment data related to the PACT Act and new patient appointment wait times.[6]

Facility leaders and staff reported shortages of primary care providers, registered nurses, licensed practical nurses, and medical staff assistants. Leaders acknowledged challenges in recruitment and retention due to the cost of living in the Seattle area and more competitive salaries at local hospitals. The OIG found the staffing shortages required leaders to work with staff to develop options for providing care, such as telehealth emergency department visits, virtual urgent care appointments, and nurse case managers and a pharmacist providing some aspects of patient care.

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

Although wait times and referrals to care in the community increased, veterans reported improved satisfaction with access to care. Primary care staff said panel sizes and coverage expectation were reasonable; however, registered nurses said they only have time to meet patients' immediate needs and were unable to create long-term care management plans for those with chronic conditions. Staff added that facility leaders were responsive to their concerns.

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. These programs served a large geographical area, covering 14 counties. The facility had the second largest Housing and Urban Development–Veterans Affairs Supportive Housing program in the country, with 3,400 housing vouchers. Program staff worked with several community partners to meet the needs of the veterans.

The OIG found two common barriers that crossed all programs: a lack of government-furnished vehicles for staff to use, and salaries that did not match local cost-of-living rates and were not competitive with other community or VA medical facilities. Program staff said they have about 160 employees who share 40 vehicles. Although leaders created a system for staff to reserve a vehicle in four-hour increments, the OIG issued a related recommendation.

A lack of cell phones for staff and safety on the job in the Housing and Urban Development–Veterans Affairs Supportive Housing program was an additional barrier. The OIG recommended the Executive Director address this vulnerability.

What the OIG Recommended

The OIG made two recommendations for improvement:

1. The Executive Director ensures homeless program staff have sufficient access to government vehicles to effectively function in their positions.
2. The Executive Director ensures Housing and Urban Development–Veterans Affairs Supportive Housing program staff have access to cell phones to independently provide services to homeless veterans.

VA Comments and OIG Response

The Veterans Integrated Service Network Director and facility Director agreed with the inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, and the responses within the body of the report for the full text of the directors' comments). Based on information provided, the OIG considers all recommendations closed.

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

Abbreviations

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

FACILITY IN CONTEXT

VA Puget Sound Health Care System
Seattle, Washington
Level 1a-High Complexity
King County
Hospital Referral Region: Seattle, WA

Description of Community

POPULATION

Female **2,478,807**	Male **2,501,512**
Veteran Female **38,154**	Veteran Male **298,288**

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

MEDIAN INCOME

$68,425

EDUCATION

92% Completed High School
67% Some College

VIOLENT CRIME

Reported Offenses per 100,000 **216**

SUBSTANCE USE

34.0% Driving Deaths Involving Alcohol
18.5% Excessive Drinking
1,574 Drug Overdose Deaths

UNEMPLOYMENT RATE

6% Unemployed Rate 16+
4% Veterans Unemployed in Civilian Workforce

TRANSPORTATION

Drive Alone	1,627,954
Work at Home	237,655
Carpool	236,275
Public Transportation	200,708
Walk to Work	98,560
Other Means	53,901

AVERAGE DRIVE TO CLOSEST VA

Primary Care	**36.5 Minutes, 31.5 Miles**
Specialty Care	**84 Minutes, 73 Miles**
Tertiary Care	**96.5 Minutes, 76.5 Miles**

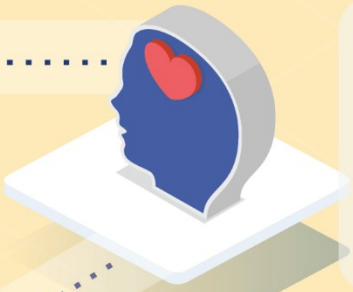
Access to Health Care

ACCESS

VA Medical Center Telehealth Patients **57,465**

Veterans Receiving Telehealth (Facility)	55%
Veterans Receiving Telehealth (VHA)	41%
<65 without Health Insurance	12%

Health of the Veteran Population



VETERANS RECEIVING MENTAL HEALTH TREATMENT AT FACILITY

27,038

335 VETERANS HOSPITALIZED FOR SUICIDAL IDEATION

AVERAGE INPATIENT HOSPITAL LENGTH OF STAY

6.68 Days

30-DAY READMISSION RATE

8%

SUICIDE RATE PER 100,000

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

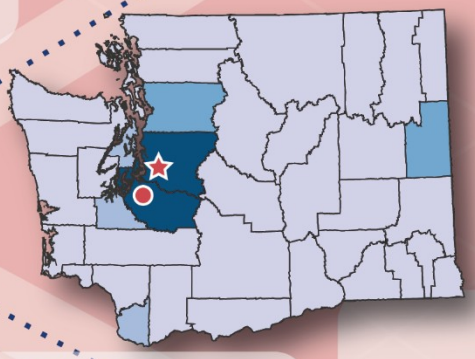
Health of the Facility

UNIQUE PATIENTS

Unique Patients VA and Non-VA Care	121K
Unique Patients VA Care	115K
Unique Patients Non-VA Care	50K

COMMUNITY CARE COSTS

Unique Patient $16,438	Outpatient Visit $358
Line Item $739	Bed Day of Care $433



STAFF RETENTION

Onboard Employees Stay <1 Yr	7.96%
Facility Total Loss Rate	14.23%
Facility Retire Rate	2.14%
Facility Quit Rate	11.04%
Facility Termination Rate	0.96%

★ Seattle VA Medical Center

● American Lake VA Medical Center

The VA Puget Sound Health Care System includes the Seattle VA Medical Center and the American Lake VA Medical Center. The OIG visited the Seattle VA Medical Center.

★ 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 (HFI) cyclical review program to help accomplish its mission. HFI 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."*

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

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

High Reliability Organization Framework

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

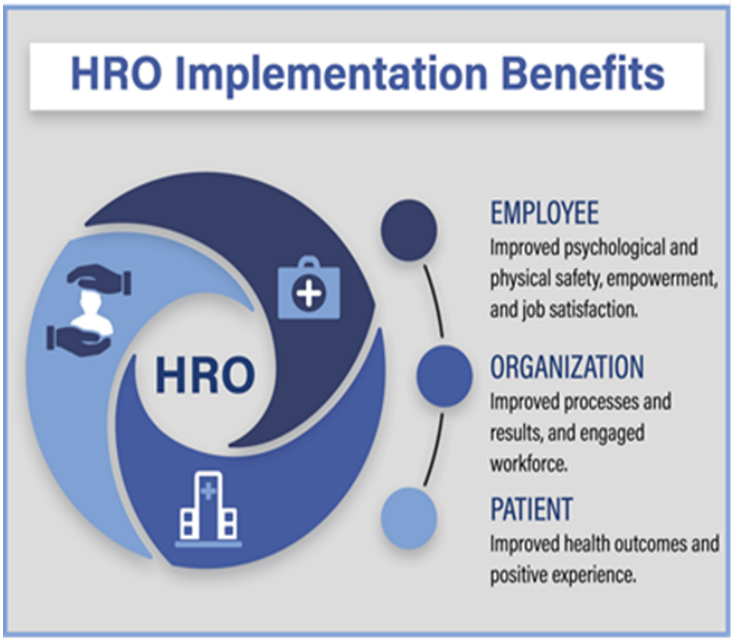


Figure 2. *Potential benefits of HRO implementation.*
Source: Department of Veterans Affairs, "VHA High Reliability Organization (HRO), 6 Essential Questions," April 2023.

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

Implementing HRO principles requires sustained commitment from leaders and employees at all levels of an organization.[7] Over time, however, facility leaders who prioritize HRO principles increase employee engagement and improve patient outcomes.[8] The OIG's inspectors observed how facility leaders

[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.

incorporated high reliability principles into their operations. Although not all facilities have formally piloted VHA's HRO framework, it is vital that facility leaders emphasize patient safety in their operational and governance decisions.

PACT Act

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

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

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

[11] Assistant Secretary for Management and Chief Financial Officer; Assistant Secretary for Human Resources and Administration/Operations, Security and Preparedness; Assistant Secretary for the Office of Enterprise Integration, "Guidance on Executing Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act Toxic Exposure Fund Initial Funding," October 21, 2022. Assistant Under Secretary for Health for Operations, "Toxic Exposure Screening Installation and Identification of Facility Navigators," October 31, 2022. Director VA Center for Development & Civic Engagement and Executive Director, Office of Patient Advocacy, "PACT Act Claims Assistance," November 22, 2022.

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

Content Domains

Figure 3. *HFI's five content domains.*
**Jeffrey Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review," BMJ Open 7, no. 11 (2017): 1–11.*
Sources: Boris Groysberg et al., "The Leader's Guide to Corporate Culture: How to Manage the Eight Critical Elements of Organizational Life," Harvard Business Review 96, no. 1 (January-February 2018): 44-52; Braithwaite et al., "Association between Organisational and Workplace Cultures, and Patient Outcomes: Systemic Review"; VHA Directive 1608(1), Comprehensive Environment of Care Program, June 21, 2021, amended September 7, 2023; VHA Directive 1050.01(1), VHA Quality and Patient Safety Programs, March 24, 2023, amended March 5, 2024; VHA Directive 1406(1), Patient Centered Management Module (PCMM) for Primary Care, June 20, 2017, amended April 17, 2024; VHA Homeless Programs Office, Fiscal Year 2022 Annual Report.

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

The VA Puget Sound Health Care System (facility) consists of two medical centers located in Tacoma (American Lake) and Seattle, Washington; seven outpatient clinics; and two Community Resource and Referral Centers.[13] According to the facility liaison, staff began caring for veterans in American Lake in March 1924, and Seattle in May 1951.

At the time of the inspection, the facility's executive team consisted of the Executive Director (Director), Deputy Executive Director, Chief of Staff, Deputy Chief of Staff, Associate Director of Patient Care Services, Deputy Associate Director of Patient Care Services, and Associate Director. The executive team had worked together since January 2024, when the Associate Director was appointed. Most of the executive leaders were appointed in fiscal years (FYs) 2022 and 2023. In FY 2023, the facility's medical care budget was $1,451,486,799. The facility provided care to 118,632 unique veterans and had 408 operating beds (204 inpatient, 121 community living center, 64 domiciliary, and 19 compensated work therapy/transitional residence beds).[14]

A 2019 study of struggling healthcare systems identified poor organizational culture as a defining feature of all included systems; leadership was one of the primary cultural deficits. "Unsupportive, underdeveloped, or non-transparent" leaders contributed to organizations with "below-average performance in patient outcomes or quality of care metrics."[15] Conversely,

[13] The Community Resource and Referral Centers were in Renton and Seattle, Washington. "VA Homeless Programs Community Resource and Referral Centers (CRRCs)," Department of Veterans Affairs, accessed July 9, 2024, https://www.va.gov/CRRC. The facility's outpatient clinics were in Edmonds, Everett, Mount Vernon, Olympia, Port Angeles, Puyallup, and Silverdale, Washington.

[14] "A Community Living Center (CLC) is a VA Nursing Home." "Geriatrics and Extended Care," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/VA_Community_Living_Centers. A domiciliary is "an active clinical rehabilitation and treatment program" for veterans. "Domiciliary Care for Homeless Veterans Program," Department of Veterans Affairs, accessed July 15, 2024, https://www.va.gov/homeless/dchv. "Compensated Work Therapy-Transitional Residence provides Veterans with assistance and coaching to find and retain jobs as they continue treatment, empowering their transition to independent living." "VA Mental Health Residential Rehabilitation Treatment," Department of Veterans Affairs, accessed August 21, 2024, https://www.mentalhealth.va.gov/va-residential-rehabilitation.

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

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

System Shocks

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

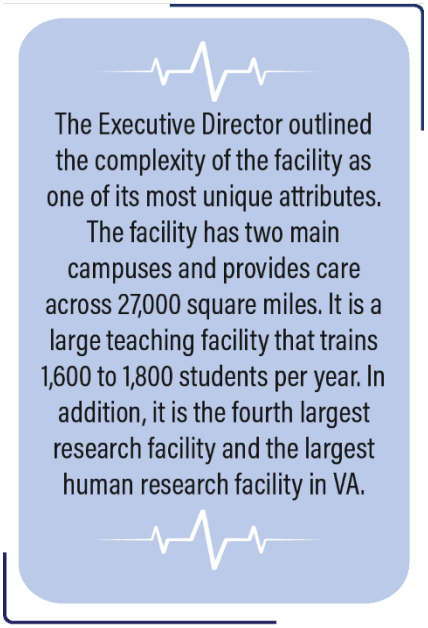


Figure 4. *Facility's unique attributes. Source: OIG interview with facility leaders.*

In an interview, executive leaders described the COVID-19 pandemic and the new Electronic Health Record Modernization program as shocks that affected the organization's culture.[20] Leaders spoke about the pandemic beginning in Washington, and the facility receiving the first veteran COVID-19 patient. They highlighted the need to change how they provided care during the pandemic, such as using

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

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

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

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

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

telehealth to see patients. Further, leaders said nursing staff transformed patient care areas into isolation units, trained the entire staff on using personal protective equipment, and clinic-based nurses volunteered to work on the inpatient units.

The leaders recognized the pandemic as a catalyst for change; since the pandemic, providers continue using telehealth to see patients. During current staffing shortages, leaders said they considered lessons learned during the pandemic to help them provide the same level of care with fewer staff.

Leaders discussed being the first large, complex facility scheduled to implement the new Oracle Cerner electronic health record system under the Electronic Health Record Modernization program; however, VHA delayed the implementation due to the complexity of services offered at the facility. During the pre-planning stage, leaders discussed areas of concern, such as conducting healthcare research and operating a facility 24 hours a day, seven days a week while implementing the system. During the planning stage, leaders scheduled staff training, which they often had to reschedule. Leaders said this happened repeatedly and created a backlog of patients needing clinical care.

Leaders emphasized that system shocks usually occur and then end; however, these shocks have not ended because patients continue to be admitted to the facility with COVID-19, and the new electronic health record system still needs to be implemented.

Leadership Communication

VHA's HRO journey includes the operational strategy of organizational transparency.[21] 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.[22] 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."[23] The OIG reviewed VA's All Employee

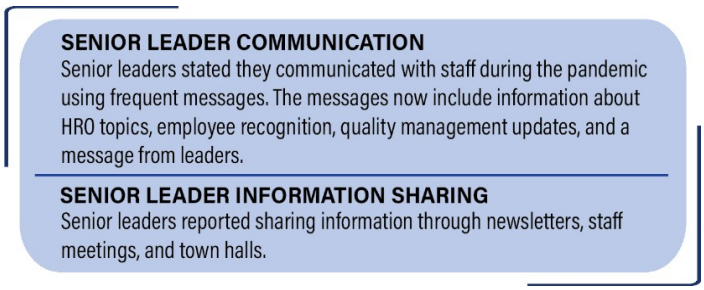


Figure 5. *Leader communication with staff.*
Source: OIG interview with facility leaders.

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

[22] 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*.

[23] 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.

Survey data and interviewed leaders to determine how they demonstrated transparency, communicated with staff, and shared information.[24]

The facility's All Employee Survey scores for communication and information sharing increased from FY 2021 to FY 2023, and transparency decreased from FY 2022 to FY 2023. However, the facility generally scored lower in these three areas compared to VHA. In an interview, executive leaders said they were aware of the scores and improving their efforts to ensure frequent and transparent communication with employees. Leaders stated they meet with employees in their work areas, listen to their concerns, and share the information learned with service leaders. To improve communication, leaders said they recently started selecting an employee on a rotating basis to attend an executive leadership meeting and then share what they learned with others.

Leaders acknowledged there are barriers to communication: not all employees use computers; some work at night and may not be available for events during the day; and employees have different preferences on how they receive information. Leaders stated they addressed these barriers by coming to the facility at night and on weekends to meet with employees, creating video messages so they can watch as they are able, sharing information in various ways, and asking managers how best to communicate with their employees. In the OIG-administered questionnaire, approximately one-third of the respondents indicated that leaders had improved how they communicate information.

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

Employee Experience

A psychologically safe environment can increase employees' fulfillment and commitment to the organization.[25] Further, employees' satisfaction with their organization correlates with improved patient safety and higher patient satisfaction scores.[26] The OIG reviewed responses to the employee questionnaire to understand their experiences of the facility's organizational culture and whether leaders' perceptions aligned with those experiences.

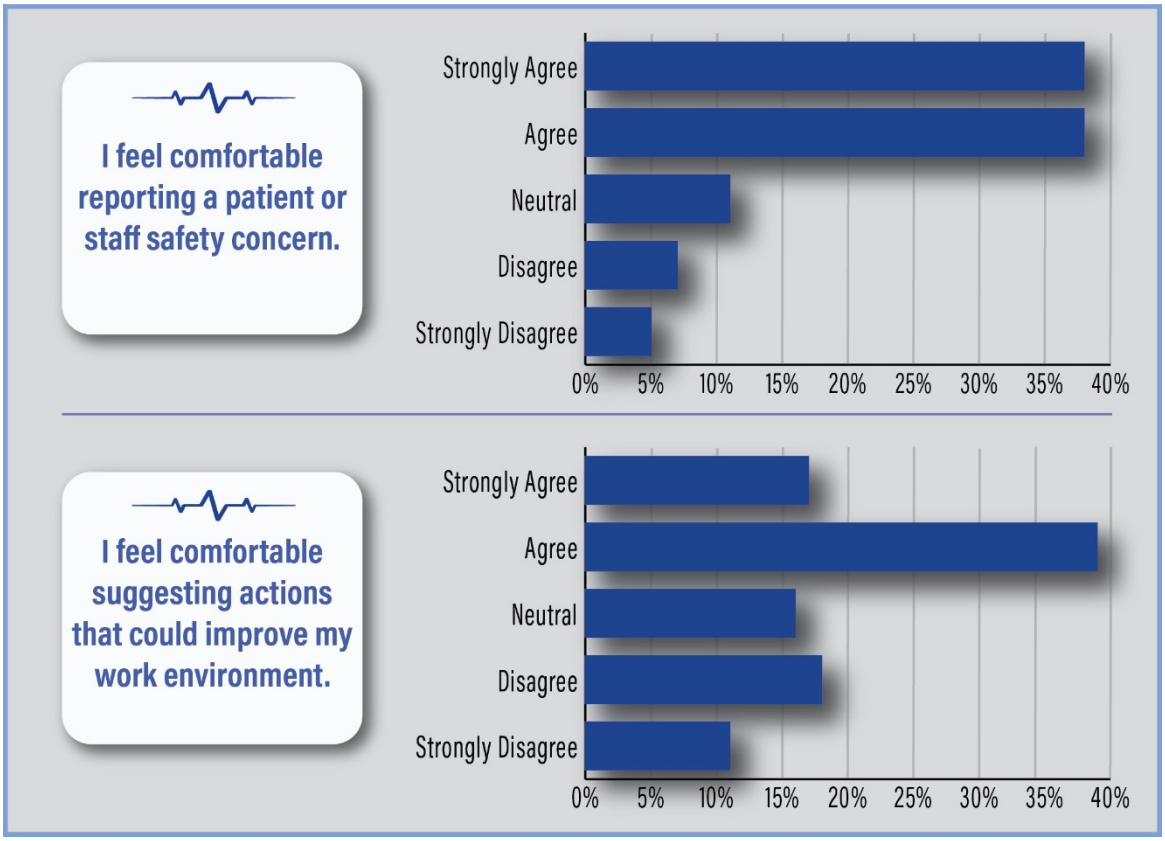


Figure 6. *Employees' perception of facility culture.*
Source: OIG questionnaire responses.

All Employee Survey scores for best places to work, no fear of reprisal, and supervisor trust increased from FYs 2022 to 2023, although the best places to work score was lower than VHA's score. Executive leaders attributed the improvement to encouraging new employees to

[25] "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.

[26] 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.

communicate issues to supervisors, and training supervisors on how to manage employees, handle complaints, and address local union concerns.

The OIG also reviewed survey scores and leaders' interview responses related to psychological safety. Leaders explained they use a just culture approach to the organization, which supports employees bringing up issues or concerns without fear of punishment, being transparent when a patient safety event occurs, and holding employees accountable.[27] They highlighted that employees reported patient safety close calls, which leaders interpreted as their willingness to communicate issues.[28] Leaders stated they are present, meet with employees, and respond to issues and concerns clearly and transparently to create a safe space.

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.[29] VSOs are non-VA, non-profit groups that provide outreach and education about VA benefits to veterans and their families.[30] The OIG reviewed patient advocate reports and VSO questionnaires to understand veterans' experiences with the facility.

In an OIG-administered questionnaire, patient advocates identified the three most common complaints from veterans as delays in access to care, especially community care; access to and timeliness of facility appointments; and billing issues.[31] Generally, the patient advocates agreed there are specific mechanisms for veterans to provide direct feedback to facility leaders. Executive leaders said veterans submit complaints or questions to the patient advocates, who track them to resolution. Leaders added they hold veteran town hall meetings to share information. The facility also has a veteran advisory committee that provides feedback and ideas to leaders. For example, one suggestion led to the creation of a garden near the café.

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[27] "Just culture is an environment that balances the need for an open and honest reporting environment with the end goal of organizational and behavioral improvement. While the organization has a duty and responsibility to employees (and ultimately to Veterans), all employees are held responsible for the quality of their choices. Just culture requires a change in focus from errors and outcomes to systems design and management of the behavioral choices of all employees." VHA Directive 1003, *VHA Veteran Patient Experience,* April 14, 2020.

[28] "A close call is an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention. Such events have also been referred to as near miss incidents." VHA Directive 1004.08, *Disclosure of Adverse Events to Patients,* October 31, 2018.

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

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

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

Additionally, leaders stated they reviewed and addressed veterans' complaints about community care billing and pharmacy delivery; they identified a point of contact for community care, who had since addressed all but one complaint, and explained to veterans they use the US Postal Service to deliver medications. Leaders also hired three nurses as patient advocates to assist veterans with complex medical needs. Leaders stated that complaints have decreased since implementing these changes.

Leaders reported meeting regularly with VSOs to share information. The only VSO respondent to the OIG's questionnaire did not identify any specific concerns but noted they provide feedback to facility leaders about care provided to veterans.

ENVIRONMENT OF CARE

The environment of care is the physical space, equipment and systems, and people that create a healthcare experience for patients, visitors, and staff.[32] To understand veterans' experiences, the OIG evaluated the facility's entry touchpoints (features that assist veterans in accessing the facility and finding their way around), including transit and parking, the main entrance, and navigation support. The OIG also interviewed staff and physically inspected patient care areas, focusing on safety, hygiene, infection prevention, and privacy. The OIG compared findings from prior inspections with data and observations from this inspection to determine if there were repeat findings and identify areas in continuing need of improvement.

Figure 7. *Facility photo. Source: "Seattle VA Medical Center," Department of Veterans Affairs, accessed March 13, 2024, https://www.va.gov/puget-sound-health-care/locations.*

Entry Touchpoints

Attention to environmental design improves patients' and staff's safety and experience.[33] The OIG assessed how a facility's physical features and entry touchpoints may shape the veteran's perception and experience of health care they receive. The OIG applied selected VA and VHA guidelines and standards, and Architectural

[32] VHA Directive 1608(1).

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

Barriers Act and Joint Commission standards when evaluating the facility's environment of care. The OIG also considered best practice principles from academic literature in the review.[34]

Transit and Parking

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

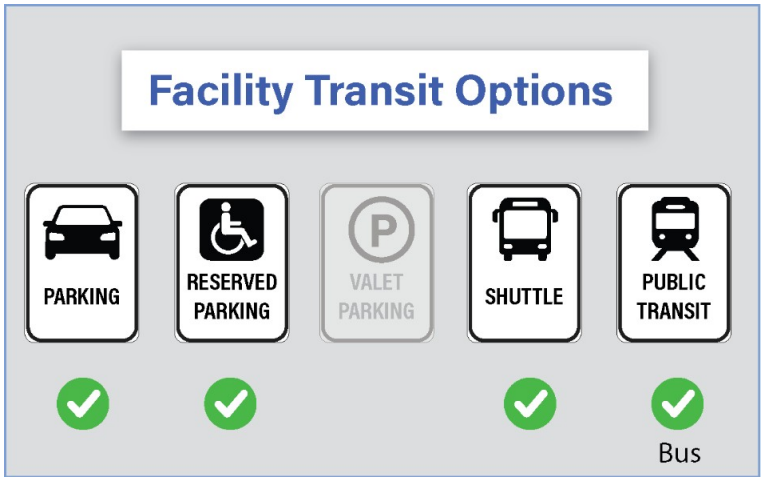

Figure 8. *Transit options for arriving at the facility.*
Source: OIG analysis of documents.

The OIG used the navigation link on the facility's public website to obtain directions. The signs directing drivers to the parking garage were clear and well placed. In the parking garage, the OIG found standard parking spaces and those accessible for veterans with disabilities, emergency call boxes, and automated external defibrillators located at the elevators on every floor. The parking garage was well lit and had security cameras throughout the structure, including in the stairwells. An OIG questionnaire respondent indicated the facility was on two public bus routes, and buses stopped approximately every 10 minutes.

Main Entrance

The OIG inspected the main entrance to determine if veterans could easily identify it and access the facility. The OIG further examined whether the space was welcoming and provided a safe, clean, and functional environment.[35]

Signs easily directed the OIG to the main entrance. The single-level main entrance had a passenger loading zone with an overhang, and sliding doors that led to a foyer that provided shelter during inclement weather. Inside the main entrance was an open circular atrium with

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

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

ample seating. The OIG also observed a vendor selling coffee, other beverages, light meal options, and snacks near the main entrance. Overall, the OIG found the main entrance to be clean and well lit.

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.[36]

The OIG noted greeters were present at the information desk to offer a wheelchair, assist with directions, provide information and maps, and escort veterans as needed. In addition, colored maps and posters were located throughout the facility to direct veterans to various locations. The OIG observed that signs and maps were up to date, except for areas currently being relocated. Facility staff provided documentation that they had requested updates and were waiting on the new signs.

The OIG also evaluated whether facility navigational cues were effective for veterans with visual and hearing sensory impairments.[37] Based on facility-provided documentation, the OIG learned that staff for the blind rehabilitation program work with veterans with visual impairments to help them achieve their desired level of independence, including with navigating the facility. Staff responded to an OIG questionnaire that the facility contracts with a sign language interpretation service to assist veterans with hearing impairments.

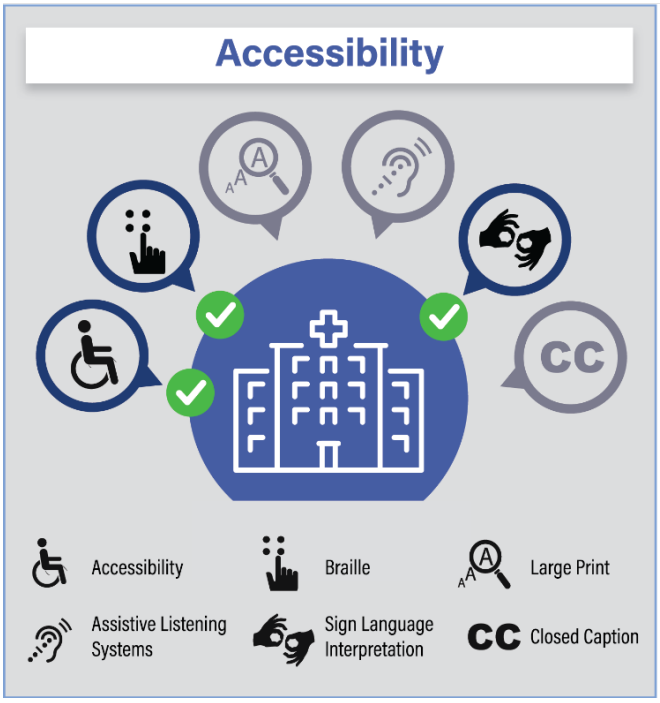

Figure 9. *Accessibility tools available to veterans with sensory impairments.*
Source: OIG analysis of documents and interviews.

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

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

Toxic Exposure Screening Navigators

VA recommends that each facility identify two toxic exposure screening navigators. The OIG reviewed the accessibility of the navigators, including wait times for screenings, at the facility based on VA's guidelines.[38]

In an interview, the OIG learned the facility had the recommended number of navigators. The OIG found that primary care clinic staff screened most veterans for toxic exposure at the facility. During an interview, the lead navigator said the facility conducts monthly outreach events and during these events, staff call veterans who need toxic exposure screenings. As of August 26, 2024, facility staff had screened 80,641 veterans, with 52 percent reporting exposure to one or more toxins.

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.

The OIG found that overall, the facility met VHA's performance target for staff closing identified environment of care deficiencies or creating an action plan to address them within 14 business days.[40] In an interview, the Chief of Environmental Management Services identified floor care as a chronic problem, with contributing factors such as staffing shortages and hiring restrictions. In response, leaders initiated a contract for additional housekeepers to clean administrative areas, which would allow facility housekeeping staff to focus on clinical areas.

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,

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

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

[40] VHA set guidance that facility should "Close deficiencies identified during CEOC [Comprehensive Environment of Care] rounds or have a documented Plan for Action (PFA) within 14 business days," with 90 percent being the minimal target for being considered fully successful. Assistant Under Secretary for Health for Support (19), "Fiscal Year 2024 Comprehensive Environment of Care Guidance Amendment (VIEWS 11685338)," memorandum to Veterans Integrated Service Network (VISN) Directors (10N1-23), May 10, 2024.

outpatient, and community living center settings focused on safety, cleanliness, infection prevention, and privacy.

The OIG inspected clinical and nonclinical areas and found them to be clean and safe, with readily available personal protective equipment.[41] The OIG observed medical equipment with evidence of current inspections, no visible protected patient information, and secured and unexpired medications. In the emergency department, the OIG noted repaired wall patches that needed painting. On the medical-surgical inpatient unit, the OIG found a damaged wall, noting staff had entered a work order for its repair; privacy curtains with holes that staff replaced during the site visit; and floors that appeared worn, possibly due to the use of electric wheelchairs. Facility leaders said it was difficult to maintain the floors (strip, wax, and polish). In response, leaders recently purchased new floor cleaning and maintenance equipment.

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.[42] 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.[43] The OIG examined the facility's processes for communication of urgent, noncritical test results to identify potential challenges and barriers that may create patient safety vulnerabilities.

The OIG found the facility had policies and processes to communicate abnormal test results to ordering providers, identify a surrogate provider when an ordering provider is unavailable or has left the facility, and communicate results outside regular clinic hours. The Chief of Staff and quality management staff explained they also assign a provider to be a backup reviewer, who

[41] The OIG inspected the emergency department, a medical-surgical inpatient unit, a critical care unit, an outpatient clinic, and a unit in the community living center.

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

[43] 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.

receives notification of unaddressed test result alerts after five to seven days. Further, the OIG found staff audit providers to monitor compliance related to the communication of test results. The Chief of Staff stated the audit is part of a performance improvement project and tied to providers' performance-based pay.

Staff identified that as a teaching hospital, they have resident providers rotating through the facility. The resident provider may enter an order for a test but rotate out of the facility before the results become available. The facility implemented a few ways to ensure a provider receives test results, including having the residents add the attending physician as the ordering provider or as an additional person so the ordering provider will receive the results.

Action Plan Implementation and Sustainability

Figure 10. *Status of prior OIG recommendations. Source: Previous OIG reports.*

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.[44] The OIG evaluated previous facility action plans in response to oversight report recommendations to determine whether action plans were implemented, effective, and sustained.

The OIG reviewed oversight reports, surveys, and reviews involving the facility and did not find any open recommendations. The interview panel explained their process to ensure action plan implementation and sustainment. If the facility receives a recommendation from an oversight agency, quality management staff work with service leaders and staff to develop action plans. In addition, quality management staff look for repeated themes within the recommendations, track the action plans to completion, monitor some action plans to ensure sustained improvement, and update executive leaders.

Continuous Learning through Process Improvement

Continuous process improvement is one of VHA's three pillars on the HRO journey toward reducing patient harm to zero.[45] Patient safety programs include process improvement initiatives to ensure facility staff are continuously learning by identifying deficiencies, implementing actions to address the deficiencies, and communicating lessons learned.[46] The OIG examined the

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

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

[46] VHA Directive 1050.01(1).

facility's policies, processes, and process improvement initiatives to determine how staff identified opportunities for improvement and shared lessons learned.

The OIG found the facility's focus on process improvement to be collaborative and robust. During an interview, staff said leaders support process improvement projects and assist with overcoming barriers. Additionally, most services champion their own process improvement projects, and quality management staff support them, as needed.

Staff also said they share information on process improvement projects during huddles, safety forums, new employee orientation, town halls, and other meetings. They discussed several completed process improvement projects. For example, leaders allowed providers to turn off alerts (notifications) on consults. Prior to this change, providers received an alert every time staff acted on a consult.

Additionally, staff told the OIG about changes they made after a patient's death in 2017. The patient came to the facility's emergency department in Seattle with chest pain. The preliminary diagnosis was myocardial infarction (heart attack), and the patient was intermittently stable and unstable. Staff needed to transfer the patient to a local hospital for a cardiac catheterization (a heart-related procedure) because the facility did not offer it. Facility staff initially had difficulty finding a local hospital to accept the patient, but eventually another hospital agreed; however, the patient died.

The quality management staff reviewed this case, identified opportunities for improvement, and developed a memorandum of understanding with one hospital and an informal agreement with a second hospital to accept patients who present to the emergency department with heart attack symptoms. Once patients receive treatment and are medically stable, they would be transferred back to the facility for ongoing care. Facility staff reported tracking data, including the number of transfers and patients' health outcomes, and found that 33 patients were transferred to a local hospital, and of those, one died. Staff said they presented this project at VHA's annual patient safety conference in June 2024.

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

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

Primary Care Teams

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

At the time of the OIG site visit, the facility had the following vacant primary care positions: 18 provider, 8 registered nurse, 1 licensed practical nurse, and 15 medical staff assistant positions. In an interview, primary care and facility leaders stated these numbers represented only positions approved for hiring; since VHA mandated national hiring ceilings in January 2024, facility leaders had to determine which positions were most critical to fill. However, to meet VHA guidelines, primary care leaders stated the actual vacancy total was approximately 90 positions.

Leaders also acknowledged challenges in recruitment and retention due to the cost of living in the Seattle area and more competitive salaries at local hospitals. To recruit primary care providers, leaders said they offered them lower patient-to-provider ratios and longer appointment times. Leaders also said they used telehealth emergency department visits, virtual urgent care appointments, and float nurses (nurses who are not assigned to primary care teams) for virtual appointments, as well as after hour and weekend clinics to address staffing shortages. Leaders reported that these changes improved veterans' satisfaction with access to care scores from 27 percent to 44 percent.

Panel size, or the number of patients assigned to a care team, reflects a team's workload; an optimally sized panel helps to ensure patients have timely access to high-quality care.[50] The OIG examined the facility's primary care teams' actual and expected panel sizes relative to VHA guidelines.[51]

The OIG found that primary care provider panel sizes exceeded the 95 percent fullness benchmark suggested by VHA, with facility documents showing 86 of the 121 primary care teams exceeding the recommended size. In interviews, facility leaders stated that primary care panel sizes, on average, were at 113 percent of the recommended size across most teams and

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

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

[50] "Manage Panel Size and Scope of the Practice," Institute for Healthcare Improvement. On April 19, 2023, the Institute for Healthcare Improvement's website contained this information (it has since been removed from their website).

[51] VHA Directive 1406(1).

attributed it to veteran population growth and their limited ability to hire staff. As a result, wait times and referrals to care in the community had increased, and primary care teams experienced more stress and burnout. Leaders asserted that when VHA implemented hiring ceilings across all VA facilities, they failed to consider the long-term effects in areas experiencing growth.

Primary care team members told the OIG that panel sizes and coverage expectations were generally reasonable, with equal workload burdens. Registered nurses said they have enough time to manage patients' daily needs but were unable to create long-term care management plans for those with chronic conditions. Overall, teams had limited time to meet and plan for patient care needs. However, staff added they meet to discuss issues and identify solutions, then elevate problems they were unable to solve to leaders for assistance.

Leadership Support

Primary care team principles include continuous process improvement to increase efficiency, which in turn improves access to care.[52] Continuous process improvement is also one of the three HRO pillars, so the OIG expects facility and primary care leaders to identify and support primary care process improvements.

In an interview, primary care team members said facility and clinic leaders were responsive to concerns and worked with them to improve efficiency and team functioning. For example, leaders ordered a second electrocardiogram (machine used to measure heart waves) for primary care use because cardiology staff predominately used the machine assigned to the clinic.

According to documentation provided by the facility, primary care staff had implemented multiple projects to improve efficiency. However, the interviewed team members said they have limited time to participate in process improvement projects due to staffing shortages and workload demands.

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. Leaders stated they had not directly targeted outreach to increase enrollment, but toxic exposure screenings, town hall meetings for women veterans, and screenings for homeless veterans had led to increased enrollment. In interviews, leaders and staff said the increased demand and staffing shortages resulted in longer appointment wait times and more veterans meeting eligibility for community care. Leaders added they monitor providers' schedules to ensure maximum availability for patient care and have nurse care managers and a pharmacist provide some aspects of care, which would free up providers' time.

[52] VHA Handbook 1101.10(2).

VETERAN-CENTERED SAFETY NET

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

Health Care for Homeless Veterans

The HCHV program's goal is to reduce veteran homelessness by increasing access to healthcare services under the reasoning that once veterans' health needs are addressed, they are better equipped to address other life goals. Program staff conduct outreach, case management, and if needed, referral to VA or community-based residential programs for specific needs such as treatment for serious mental illness or substance use.[53]

> Program staff have developed a comprehensive resource guidebook for veterans and non-veterans, published quarterly, covering the facility's 14 county service area's VA and non-VA partner resources.

Figure 11. *Resource guidebook. Source: OIG interview.*

Identification and Enrollment of Veterans

VHA measures HCHV program success by the percentage of unsheltered veterans who receive a program intake assessment (performance measure HCHV5).[54] VA uses the Department of Housing and Urban Development's point-in-time count as part of the performance measure that "estimates the homeless population nationwide."[55]

While the program did not meet the HCHV5 target from FYs 2021 through 2023, the OIG noted a favorable performance trend, which staff largely attributed to the facility's reopened Community Resource and Referral Center in Seattle.[56] In an interview, the program staff

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

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

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

[56] Community Resource and Referral Centers "provide Veterans who are homeless and at risk of homelessness with one-stop access to community based, multiagency services to promote permanent housing, health and mental health care, career development and access to VA and non-VA benefits." "VA Homeless Programs Community Resource and Referral Centers (CRRCs)," Department of Veterans Affairs, accessed July 9, 2024, https://www.va.gov/CRRC. The Community Resource and Referral Center initially opened in 2019, but then closed in 2020 due to pandemic. It has since reopened. The HCHV5's target is 100 percent by the end of the FY. The facility was at 52.57 percent in FY 2021, 75.3 percent in FY 2022, and 83.28 percent in FY 2023.

reported limited staffing as a barrier to engaging veterans and enrolling them in the program. Staff said they had 16 full-time employees and one part-time employee who provided services to veterans predominantly in the Seattle and Tacoma area; Housing and Urban Development–Veterans Affairs Supportive Housing staff located in outer areas conduct outreach services. In addition to the Community Resource and Referral Center, the program's services included outreach, contracted emergency housing, transitional living services, and two walk-in clinics located in Seattle and American Lake.

Program staff reported they participate in the point-in-time count; however, they do not find the data accurate. The staff explained that community-based Continuum of Care programs maintain a list of homeless people, including veterans and the services they are receiving. The programs update the list regularly, and staff find it to be more accurate than the count.[57]

Additionally, program staff reported multiple ways they conduct outreach and engage veterans in care. These efforts included visiting homeless shelters and day centers, conferencing with community partners on cases, responding to inquiries from the facility's Patient Advocate Office, and working with local law enforcement. Staff track their outreach and engagement efforts and monitor caseload sizes, workload productivity, and veterans' exits from the program.

When the OIG asked about the program's successes, staff spoke of a recently opened project-based property that provided housing for aging, vulnerable veterans.[58] Through outreach efforts, staff identified and housed 25 unsheltered senior veterans at the site.

[57] The Continuum of Care Program promotes a community-wide commitment to end homelessness, provide funding to non-profit, state and local governments to rehouse individuals and families, and to help optimize self-sufficiency. "Continuum of Care Program," Department of Housing and Urban Development, accessed August 5, 2024, https://www.hud.gov/ContinuumOfCare.

[58] For project-based properties, rental assistance "is attached to specific units in a building (often all the units of the building)." Department of Housing and Urban Development, *Fact Sheet #4: The Difference Between Project-Based Vouchers (PVB) and Project-Based Rental Assistance (PBRA)*, accessed February 11, 2025, https://www.hud.gov/FactSheet4.pdf. The facility has 800 project-based subsidized units.

Meeting Veteran Needs

VHA measures the percentage of veterans who are discharged from HCHV into permanent housing (performance measure HCHV1) and the percentage of veterans who are discharged due to a "violation of program rules…failure to comply with program requirements…or [who] left the program without consulting staff" (performance measure HCHV2).[59]

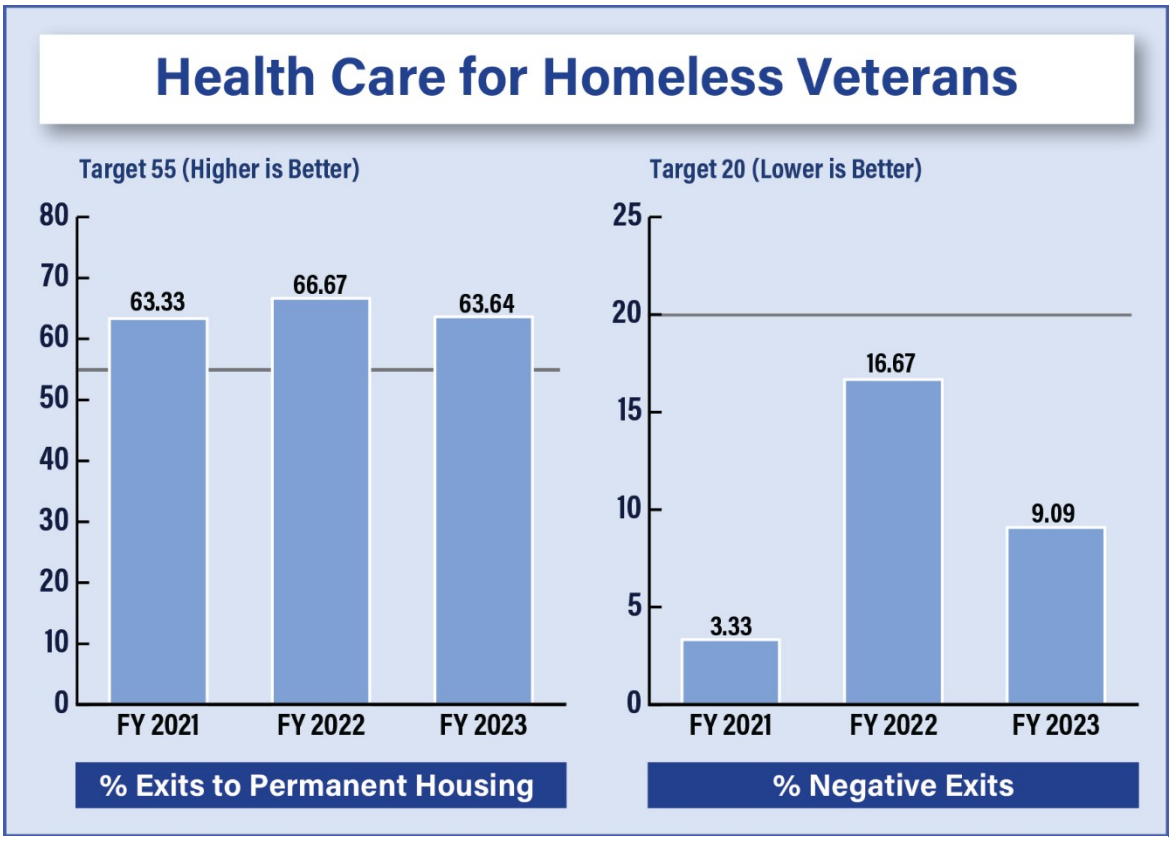

Figure 12. *HCHV program performance measures.*
Source: VHA Homeless Performance Measures data.

The OIG found the facility met the HCHV1 and HCHV2 targets for FYs 2021, 2022, and 2023. In an interview, program staff stated they contract with a community partner to manage the emergency housing program and included meeting the performance targets in the contract. The community partner provides case management and mental health services, while the facility's homeless primary care team offers medical care to the veterans at the site. Program staff monitor the metrics monthly and address deficiencies with the community partner when they arise. According to program staff, the primary reason for negative exits involves veterans' lack of

[59] VHA sets targets for HCHV1 and HCHV2 at the national level each year. 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*.

engagement. Staff stated that when a negative exit occurs, they reach out to the veteran to provide other services or housing options.

The OIG noted a common challenge to staff meeting veterans' needs across all three homeless programs (HCHV, Veterans Justice Program, and Housing and Urban Development–Veterans Affairs Supportive Housing) was the lack of transportation. First, the homeless program staff said the homeless programs have approximately 160 staff members covering 14 counties, and they share 40 government vehicles, or 1 vehicle per 4 staff members. To compensate for the lack of vehicles, program leaders developed a reservation system so staff could sign up for a vehicle in four-hour increments. The OIG recommends the Executive Director ensures homeless program staff have sufficient access to government vehicles to effectively function in their positions.

Second, according to program staff, during the pandemic, homeless programs had access to funds to pay for veterans to use rideshare programs. Staff said the rideshare program offered flexibility and helped with transporting veterans to VA and non-VA services. With the end of the pandemic, the rideshare funds expired. Homeless staff stated they transported veterans as they were able, provided bus passes, and relied on community partners to assist with transportation needs.

A final challenge identified by the homeless program staff was recruitment and retention. Staff said the facility's salary rate did not match the cost-of-living rate for the area, and the facility was not competitive with community healthcare systems and other VA facilities. In response, program leaders modified work schedules to allow staff to have a routine day off, which increased their satisfaction. The OIG requests the Executive Director to consider reviewing salary rates and adjusting them to meet the cost of living and be more competitive.

Veterans Justice Program

"Incarceration is one of the most powerful predictors of homelessness."[60] 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.[61]

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

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

Identification and Enrollment of Veterans

VHA measures the number of veterans entering Veterans Justice Programs each FY (performance measure VJP1).[62] The OIG found the program met the performance measure target for FY 2023. In an interview, program staff attributed meeting the target to ensuring all enrolled veterans had a completed intake assessment. Staff informed the OIG the program had five justice outreach workers and a supervisor. Documentation provided to the OIG showed 10 veterans treatment courts across five counties, and 24 jails within the facility's service area.[63]

Staff reported and provided documentation on conducting outreach to 4 jails and providing ad hoc services at 3 additional jails, as well as presenting and participating in community-based committees and meetings.[64] In addition to outreach, program staff actively participate in veterans treatment courts by attending court hearings and meetings and updating the court and probation officers about veterans' treatment. Additionally, a Veterans Integrated Service Network employee reported meeting with and connecting veterans incarcerated in the 11 state prisons and one federal detention center located within the facility's service area to VA services after release.[65] Staff said they receive referrals from a variety of sources, including family members, law enforcement employees, clinicians, defense attorneys, and prosecutors.

Meeting Veteran Needs

In an OIG-administered questionnaire, program staff outlined the program's objectives for participants, including engagement in treatment, such as mental health or substance use, obtaining stable housing, and resolving legal problems. In an interview, program staff explained they assess veterans entering the program and, based on the results, refer them for various services, such as mental health or substance use treatment and housing assistance. Staff stated they coordinate care with facility providers and community programs and monitor the veteran's participation in treatment, inform providers about the veteran's involvement in the justice system, and update the veterans treatment courts. One staff member explained the program's focus is ensuring veterans can access services. Another staff member mentioned that veterans

[62] 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*.

[63] A veterans treatment court is "a treatment court model that brings Veterans together on one docket to be served as a group. A treatment court is a long-term, judicially supervised, often multi-phased program through which criminal offenders are provided with treatment and other services that are monitored by a team which usually includes a judge, prosecutor, defense counsel, law enforcement officer, probation officer, court coordinator, treatment provider and case manager." VHA Directive 1162.06, *Veterans Justice Programs*, April 4, 2024.

[64] According to program staff, they were not currently providing outreach services to the 6 tribal jails.

[65] 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/.

graduated from veterans treatment court when they completed all phases of the program, enrolled in school or gained employment, and had not broken the law again.

A third staff member identified barriers to care for veterans and explained how some of them directly affect veterans with court-mandated treatment requirements. For example, staff said veterans prefer to receive their mental health and substance use treatment at the facility because it was more comprehensive; however, staffing shortages have created long wait times, which could result in a veteran staying in jail longer while waiting for services. Staff said veterans cannot participate in veterans treatment court until they are engaged in treatment, so they advocate for them with facility and community providers. Staff also mentioned that it was particularly challenging to locate therapists who treat sex offenders in Washington due to a limited number of therapists who specialize in this area. Finally, staff stated they could previously provide smartphones to veterans released from custody to communicate with them and coordinate care, but that program has also ended.

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."[66] 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.[67]

> The Homeless Program, consisting of HCHV, Veterans Justice, and Housing and Urban Development–Veterans Affairs Supportive Housing program among others, was without a director for two years. When hired, the current Homeless Program Director focused on hiring and training qualified staff, complying with policies and directives, and reorganizing and standardizing the program. Staff now communicate and collaborate across the homeless programs.

Figure 13. *Reorganizing the homeless programs.*
Source: OIG interview.

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).[68] The OIG found the

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

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

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

program did not meet the target for FYs 2021 through 2023.[69] In an interview, program staff attributed it to a delay in opening project-based subsidized units and limiting admissions to the program because of staffing challenges. Staff added that if the units had opened on time, many veterans would have moved into permanent housing and the program would have met this metric.

According to staff, the program is the second largest in the country, with 3,400 vouchers and an 80 percent utilization rate; it has 118 staff members who work with 14 housing authorities in as many counties.

Meeting Veteran Needs

VHA measures how well the Housing and Urban Development–Veterans Affairs Supportive Housing program is meeting veteran needs by using nationally determined targets including the percentage of veterans employed at the end of each month (performance measure VASH3).[70] The OIG found the facility did not meet the target for FYs 2021 through 2023.[71] According to staff, the employment coordinator position in Seattle has been vacant for over a year, and the coordinator would work with veterans to determine their employment interest and update the tracking information as needed.

In addition to having limited access to government vehicles, staff said they have trouble obtaining and maintaining facility-provided cell phones. An employee who started in February 2024 still did not have a cell phone at the time of the OIG's site visit. For safety reasons, the employee is unable to do independent site visits without having a VA-provided cell phone. The OIG recommends the Executive Director ensures Housing and Urban Development–Veterans Affairs Supportive Housing program staff have access to cell phones to independently provide services to homeless veterans.

Program staff reported strong relationships with community partners, who assist with monetary needs, such as security deposits, overdue rent, and utility assistance; and tangible resources, such as food, furniture, bus and rail passes, and clothing. Partners also provide medical and mental health care for veterans who are ineligible for VA care. To avoid duplication of efforts, program staff coordinate outreach to identify veterans who need assistance and locate those lost to follow-

[69] The FYs 2021 and 2022 target for HMLS3 was 92 percent. VHA Homeless Programs Office, *Technical Manual: FY 2021 Homeless Performance Measures*, October 1, 2020; VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures*, October 1, 2021.

[70] 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*.

[71] The VASH3 targets for FYs 2021 and 2022 were 45 and 47 percent, respectively. VHA Homeless Programs Office, *Technical Manual: FY 2021 Homeless Performance Measures*; VHA Homeless Programs Office, *Technical Manual: FY 2022 Homeless Performance Measures.* For VASH3, the facility was at 39.43 percent for FY 2021, 37.17 percent for FY 2022, and 36.04 percent for FY 2023.

up. Additionally, program staff said they build relationships with the various Continuum of Care programs and participate on committees to ensure veterans receive community services.

Conclusion

To assist leaders in evaluating the quality of care at their facility, the OIG conducted a review across five content domains and provided recommendations on systemic issues that may adversely affect patient care. Recommendations do not reflect the overall quality of all services delivered within the facility. However, the OIG's findings and recommendations may help guide improvement at this and other VHA healthcare facilities. The OIG appreciates the participation and cooperation of VHA staff during this inspection process.

OIG Recommendations and VA Response

Finding: Homeless program staff lacked access to government vehicles necessary to effectively function in their positions.

Recommendation 1

The OIG recommends the Executive Director ensures homeless program staff have sufficient access to government vehicles to effectively function in their positions.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

The HUDVASH program identified challenges with efficient utilization of their fleet vehicles and learned that the vehicles were being underutilized based on how they were being reserved. Staff do not require the daily use of fleet vehicles and have autonomy in scheduling. To maximize the utilization of vehicles and allow staff scheduling flexibility to meet Veteran care needs, in 2023, a process was established to reserve vehicles in four-hour increments. To improve functionality, a Microsoft Teams reservation form with defined timeframes was implemented in December 2024. To further support the process, daily vehicle updates were also introduced to inform staff of available vehicles for last minute utilization. These changes have significantly enhanced both the accessibility and utilization of available government vehicle resources. As a result of more efficient utilization and oversight, the existing fleet meets the HUDVASH program needs without requiring further vehicle acquisition. We request closure of this item.

OIG Comments

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

Finding: Housing and Urban Development–Veterans Affairs Supportive Housing program staff did not have cell phones necessary to perform their duties.

Recommendation 2

The OIG recommends the Executive Director ensures Housing and Urban Development–Veterans Affairs Supportive Housing program staff have access to cell phones to independently provide services to homeless veterans.

__X__ Concur

____ Nonconcur

Target date for completion: Completed

Director Comments

At the time of the survey, there was a limited supply of government-furnished cell phones available for issuance to staff. While no social workers were denied access to a phone, the average wait time to receive one was approximately 3 to 4 months. To mitigate safety concerns, the VA Puget Sound Social Work Standard Operating Procedure (SOP) SWS-1, Social Work Service Safety in the Community, outlines that staff must obtain an agency provided phone prior to completing independent community-based visits. As of January 2025, all HUDVASH supportive housing staff had been issued cell phones. We request closure of this item.

OIG Comments

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

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 four VSOs.[2] Additionally, the OIG interviewed facility leaders and staff to discuss processes, validate findings, and explore reasons for noncompliance. Finally, the OIG inspected selected areas of the medical facility.

The OIG's analyses relied on inspectors identifying significant information from questionnaires, surveys, interviews, documents, and observational data, based on professional judgment, as supported by Council of Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation.*[3]

Potential limitations include self-selection bias and response bias of respondents.[4] The OIG acknowledges potential bias because the facility liaison selected staff who participated in the primary care panel issues.

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.

[1] The All Employee Survey and accreditation reports covered the time frame of October 1, 2020, through September 30, 2023.

[2] The OIG sent questionnaires to four VSOs (American Legion, Disabled American Veterans, Veterans of Foreign Wars, and Paralyzed Veterans of America).

[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.

[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.*

Table B.2. Health of the Veteran Population*

Category	Metric	Metric Definition
Mental Health Treatment	Veterans Receiving Mental Health Treatment at Facility	Number of unique patients with at least one encounter in the Mental Health Clinic Practice Management Grouping. An encounter is a professional contact between a patient and a practitioner with primary responsibility for diagnosing, evaluating, and treating the patient's condition. Encounters occur in both the outpatient and inpatient setting. Contact can include face-to-face interactions or telemedicine.
Suicide	Suicide Rate	Suicide surveillance processes include close coordination with federal colleagues in the Department of Defense (DoD) and the Centers for Disease Control and Prevention (CDC), including VA/DoD searches of death certificate data from the CDC's National Death Index, data processing, and determination of decedent Veteran status.
	Veterans Hospitalized for Suicidal Ideation	Distinct count of patients with inpatient diagnosis of ICD10 Code, R45.851 (suicidal ideations).
Average Inpatient Hospital Length of Stay	Average Inpatient Hospital Length of Stay	The number of days the patient was hospitalized (the sum of patient-level lengths of stay by physician treating specialty during a hospitalization divided by 24).
30-Day Readmission Rate	30-Day Readmission Rate	The proportion of patients who were readmitted (for any cause) to the acute care wards of any VA hospital within 30 days following discharge from a VA hospital by total number of index hospitalizations.
Unique Patients	Unique Patients VA and Non-VA Care	Measure represents the total number of unique patients for all data sources, including the pharmacy-only patients.
Community Care Costs	Unique Patient	Measure represents the Financial Management System Disbursed Amount divided by Unique Patients.
	Outpatient Visit	Measure represents the Financial Management System Disbursed Amount divided by the number of Outpatient Visits.
	Line Item	Measure represents the Financial Management System Disbursed Amount divided by Line Items.
	Bed Day of Care	Measure represents the Financial Management System Disbursed Amount divided by the Authorized Bed Days of Care.
Staff Retention	Onboard Employees Stay < 1 Year	VA's AES All Employee Survey Years Served <1 Year divided by total onboard. Onboard employee represents the number of positions filled as of the last day of the most recent month. Usually one position is filled by one unique employee.
	Facility Total Loss Rate	Any loss, retirement, death, termination, or voluntary separation that removes the employee from the VA completely.

Category	Metric	Metric Definition
	Facility Quit Rate	Voluntary resignations and losses to another federal agency.
	Facility Retire Rate	All retirements.
	Facility Termination Rate	Terminations including resignations and retirements in lieu of termination but excluding losses to military, transfers, and expired appointments.

**The OIG updates information for the Facility in Context graphics quarterly based on the most recent data available from each source at the time of the inspection.*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 8, 2025

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

Subj: Healthcare Facility Inspection of VA Puget Sound Health Care System in Seattle, Washington

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

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

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

(Original signed by:)
Teresa D. Boyd D.O.

Appendix D: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 4, 2025

From: Director, VA Puget Sound Health Care System (663)

Subj: Healthcare Facility Inspection of the VA Puget Sound Health Care System in Seattle, Washington

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

1. Thank you for the opportunity to review and respond to the draft report from the Healthcare Facility Inspection of the VA Puget Sound Health Care System in Seattle, Washington.
2. I have reviewed the report and concur with all findings and recommendations as written. Comments regarding the contents of this memorandum may be directed to the Puget Sound VA Medical Center's Director of Quality and Patient Safety.

(Original signed by:)

Thomas Bundt, PhD., FACHE
Medical Center Director

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