Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 13-00890-220

Combined Assessment Program Review of the Alaska VA Healthcare System Anchorage, Alaska

June 20, 2013

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CLC	community living center
COS	Chief of Staff
CS	controlled substances
DOD	Department of Defense
EHR	electronic health record
EOC	environment of care
facility	Alaska VA Healthcare System
FPPE	Focused Professional Practice Evaluation
FY	fiscal year
HPC	hospice and palliative care
HRCP	Home Respiratory Care Program
MEC	Medical Executive Committee
MH RRTP	Mental Health Residential Rehabilitation Treatment Program
NA	not applicable
NC	noncompliant
OIG	Office of Inspector General
PCCT	Palliative Care Consult Team
PRC	Peer Review Committee
QM	quality management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of March 25, 2013.

Review Results: The review covered eight activities. We made no recommendations in the following four activities:

- Environment of Care
- Preventable Pulmonary Embolism
- Continuity of Care – Fee Basis
- Mental Health Residential Rehabilitation Treatment Program

The facility's reported accomplishments were the Department of Defense/VA Joint Venture at Joint Base Elmendorf-Richardson and the facility's telehealth program, both of which have improved veteran access to care.

Recommendations: We made recommendations in the following four activities:

Quality Management: Ensure actions from peer reviews are completed and reported to the Peer Review Committee. Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners, and consistently report results to the Medical Executive Committee. Review the quality of entries in the electronic health record.

Medication Management – Controlled Substances Inspections: Ensure quarterly trend reports summarize any discrepancies and problematic trends and identify potential areas for improvement. Require that controlled substances inspectors receive annual updates and refresher training. Adhere to local policy related to the return of "Green Sheets" to the pharmacy, and ensure all elements required for the processing of prescriptions are present. Maintain documentation of controlled substances inspector orientation, training, annual updates, and annual competency assessments. Ensure controlled substances inspectors initial and date Controlled Substances Inspecting Official Checklists, VA controlled substances forms, and pharmacy activity logs.

Coordination of Care – Hospice and Palliative Care: Establish a process to track hospice and palliative care consults that are not acted upon within 7 days of the request.

Long-Term Home Oxygen Therapy: Ensure the Chief of Staff reviews Home Respiratory Care Program activities in a timely manner. Identify high-risk home oxygen patients.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 18–23, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

We reviewed selected clinical and administrative activities to evaluate compliance with requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management – CS Inspections
- Coordination of Care – HPC
- Long-Term Home Oxygen Therapy
- Preventable Pulmonary Embolism
- Continuity of Care – Fee Basis
- MH RRTP

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2011, FY 2012, and FY 2013 through March 28, 2013, and was done in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Alaska VA Healthcare System, Anchorage, Alaska,* Report No. 11-02080-286, September 21, 2011).

During this review, we presented crime awareness briefings for 122 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. An electronic survey was made available to all facility employees, and 160 responded. We shared survey results with the facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Reported Accomplishments

DOD/VA Joint Venture

The DOD/VA Joint Venture at Joint Base Elmendorf-Richardson has improved veteran access to specialty care, emergency department services, and acute inpatient care. In addition, in FY 2012, the joint venture was approved for a cardiology Joint Incentive Fund initiative with a goal to recapture 70 percent of the DOD/VA cardiology consultations and non-invasive cardiac diagnostic testing workload.

Telehealth Program

The facility's telehealth program concluded FY 2012 with the highest Virtual Care modality score in VISN 20. Successes in the program included integrating volunteers to improve outreach, using telehealth technology to improve access to remote specialists, increasing dermatology access, providing end user education, managing cases remotely, and exceeding all Secure Messaging program goals.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility complied with selected requirements within its QM program.[1]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, EHRs, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a senior-level committee/group responsible for QM/performance improvement, and it included the required members.	
	There was evidence that Inpatient Evaluation Center data was discussed by senior managers.	
X	Corrective actions from the protected peer review process were reported to the PRC.	Nine months of PRC meeting minutes reviewed: • None of the seven actions expected to be completed were reported to the PRC.
X	FPPEs for newly hired licensed independent practitioners complied with selected requirements.	Seven profiles reviewed: • Three FPPEs were not initiated. • Of the four FPPEs completed, results of two were not reported to the MEC.
NA	Local policy for the use of observation beds complied with selected requirements.	
NA	Data regarding appropriateness of observation bed use was gathered, and conversions to acute admissions were less than 30 percent, or the facility had reassessed observation criteria and proper utilization.	
NA	Staff performed continuing stay reviews on at least 75 percent of patients in acute beds.	
NA	Appropriate processes were in place to prevent incidents of surgical items being retained in a patient following surgery.	
	The cardiopulmonary resuscitation review policy and processes complied with requirements for reviews of episodes of care where resuscitation was attempted.	
X	There was an EHR quality review committee, and the review process complied with selected requirements.	Twelve months of EHR Committee meeting minutes reviewed: • There was no evidence that the quality of entries in the EHR was reviewed.

NC	Areas Reviewed (continued)	Findings
	The EHR copy and paste function was monitored.	
	Appropriate quality control processes were in place for non-VA care documents, and the documents were scanned into EHRs.	
NA	Use and review of blood/transfusions complied with selected requirements.	
NA	CLC minimum data set forms were transmitted to the data center with the required frequency.	
	Overall, if significant issues were identified, actions were taken and evaluated for effectiveness.	
	There was evidence at the senior leadership level that QM, patient safety, and systems redesign were integrated.	
	Overall, there was evidence that senior managers were involved in performance improvement over the past 12 months.	
	Overall, the facility had a comprehensive, effective QM/performance improvement program over the past 12 months.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

1. We recommended that processes be strengthened to ensure that actions from peer reviews are completed and reported to the PRC.

2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are consistently reported to the MEC.

3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements.[2]

We inspected the audiology, primary care, women's health, and occupational and physical therapy outpatient clinics. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed for General EOC	Findings
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure.	
	An infection prevention risk assessment was conducted, and actions were implemented to address high-risk areas.	
	Infection Prevention/Control Committee minutes documented discussion of identified problem areas and follow-up on implemented actions and included analysis of surveillance activities and data.	
	The facility had a policy that detailed cleaning of equipment between patients.	
	Patient care areas were clean.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Sensitive patient information was protected, and patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for the Women's Health Clinic	
	The Women Veterans Program Manager completed required annual EOC evaluations, and the facility tracked women's health-related deficiencies to closure.	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	

NC	Areas Reviewed for the Women's Health Clinic (continued)	Findings
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	
	Areas Reviewed for Physical Medicine and Rehabilitation Therapy Clinics	
	Fire safety requirements were met.	
	Environmental safety requirements were met.	
	Infection prevention requirements were met.	
	Medication safety and security requirements were met.	
	Patient privacy requirements were met.	
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	

Medication Management – CS Inspections

The purpose of this review was to determine whether the facility complied with requirements related to CS security and inspections.[3]

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of all CS Coordinators and 10 CS inspectors and inspection documentation from 3 CS areas and the outpatient pharmacy. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	Facility policy was consistent with VHA requirements.	
	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and any identified deficiencies were corrected.	
NA	Instructions for inspecting automated dispensing machines were documented, included all required elements, and were followed.	
X	Monthly CS inspection findings summaries and quarterly trend reports were provided to the facility Director.	Summary of CS inspection findings for past 6 months and quarterly trend reports for past 4 quarters reviewed: • Quarterly trend reports did not clearly summarize discrepancies and problematic trends nor did they identify potential areas for improvement.
	CS Coordinator position description(s) or functional statement(s) included duties, and CS Coordinator(s) completed required certification and were free from conflicts of interest.	
X	CS inspectors were appointed in writing, completed required certification and training, and were free from conflicts of interest.	Appointments, certifications, and training records reviewed: • CS inspectors did not receive annual updates and refresher training regarding problematic issues identified through external survey findings and other quality control measures.
	Non-pharmacy areas with CS were inspected in accordance with VHA requirements, and inspections included all required elements.	
	Pharmacy CS inspections were conducted in accordance with VHA requirements and included all required elements.	

NC	Areas Reviewed (continued)	Findings
X	The facility complied with any additional elements required by VHA or local policy.	Facility policy on CS procedures and inspection of CS reviewed: • Requirements regarding pharmacy processing of "Green Sheets" and filling of CS prescriptions were not adhered to. • Documentation of orientation, training, annual updates, and annual competency assessments for CS inspectors was not maintained. • CS Inspecting Official Checklists, VA CS forms, and pharmacy activity logs were not initialed and dated by CS inspectors.

Recommendations

4. We recommended that processes be strengthened to ensure that quarterly trend reports summarize any discrepancies and problematic trends and identify potential areas for improvement.

5. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and refresher training regarding problematic issues identified through external survey findings and other quality control measures.

6. We recommended that processes be strengthened to ensure that local policy related to the return of "Green Sheets" to the pharmacy is adhered to and that all elements required for the processing of prescriptions are present.

7. We recommended that processes be strengthened to ensure that documentation of CS inspector orientation, training, annual updates, and annual competency assessments are maintained.

8. We recommended that processes be strengthened to ensure that CS inspectors initial and date CS Inspecting Official Checklists, VA CS forms, and pharmacy activity logs.

Coordination of Care – HPC

The purpose of this review was to determine whether the facility complied with selected requirements related to HPC, including PCCT, consults, and inpatient services.[4]

We reviewed relevant documents, 13 EHRs of outpatients who had PCCT consults, and 8 non-HPC staff training records, and we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
NA[1]	A PCCT was in place and had the dedicated staff required.	
	The PCCT actively sought patients appropriate for HPC.	
	The PCCT offered end-of-life training.	
	Selected non-HPC staff had end-of-life training.	
	The facility had a VA liaison with community hospice programs.	
	The PCCT promoted patient choice of location for hospice care.	
NA	The CLC-based hospice program offered bereavement services.	
	The HPC consult contained the word "palliative" or "hospice" in the title.	
	HPC consults were submitted through the Computerized Patient Record System.	
X	The PCCT responded to consults within the required timeframe and tracked consults that had not been acted upon.	• Three consults were not acted upon within 7 days of the request and had not been tracked.
	Consult responses were attached to HPC consult requests.	
NA	The facility submitted the required electronic data for HPC through the VHA Support Service Center.	
NA	An interdisciplinary team care plan was completed for HPC inpatients within the facility's specified timeframe.	
NA	HPC inpatients were assessed for pain with the frequency required by local policy.	
NA	HPC inpatients' pain was managed according to the interventions included in the care plan.	

[1] The facility is not required to have a PCCT since it has no inpatients. Functions typically performed by the PCCT are performed by Home Based Primary Care staff.

NC	Areas Reviewed (continued)	Findings
NA	HPC inpatients were screened for an advanced directive upon admission and according to local policy.	
	The facility complied with any additional elements required by VHA or local policy.	

Recommendation

9. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

Long-Term Home Oxygen Therapy

The purpose of this review was to determine whether the facility complied with requirements for long-term home oxygen therapy in its mandated HRCP.[5]

We reviewed relevant documents and 35 EHRs of patients enrolled in the home oxygen program, and we conversed with key employees. The table below shows the areas reviewed for this topic. The areas marked as NC needed improvement. Items that did not apply to this facility are marked "NA."

NC	Areas Reviewed	Findings
	There was a local policy to reduce the fire hazards of smoking associated with oxygen treatment.	
X	The COS reviewed HRCP activities at least quarterly.	• Although we found evidence of reviews by the COS, the reviews were not timely and were not conducted quarterly.
	The facility had established a home respiratory care team.	
	Contracts for oxygen delivery contained all required elements and were monitored quarterly.	
	Home oxygen program patients had active orders/prescriptions for home oxygen and were re-evaluated for home oxygen therapy annually after the first year.	
	Patients identified as high risk received hazards education at least every 6 months after initial delivery.	
X	High-risk patients were identified and referred to a multidisciplinary clinical committee for review.	• We found no evidence that patients were being identified as high risk.
	The facility complied with any additional elements required by VHA or local policy.	

Recommendations

10. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities in a timely manner.

11. We recommended that processes be strengthened to ensure that high-risk home oxygen patients are identified.

Preventable Pulmonary Embolism

The purpose of this review was to evaluate the care provided to patients who were treated at the facility and developed potentially preventable pulmonary embolism.[6]

We reviewed relevant documents and five EHRs of patients with confirmed diagnoses of pulmonary embolism[b] January 1–June 30, 2012. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Patients with potentially preventable pulmonary emboli received appropriate anticoagulation medication prior to the event.	
	No additional quality of care issues were identified with the patients' care.	
	The facility complied with any additional elements required by VHA or local policy/protocols.	

[b] A sudden blockage in a lung artery usually caused by a blood clot that travels to the lung from a vein in the body, most commonly in the legs.

Continuity of Care – Fee Basis

The purpose of this review was to evaluate whether information from patients' community hospitalizations at VA expense was available to the VA clinic providers. Such information is essential to continuity of care and optimal patient outcomes.

We reviewed relevant documents and 30 EHRs of patients who had been hospitalized from January to December 2012 in the local community at VA expense, and we conversed with key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	Clinical information was available to the primary care team for the clinic visit subsequent to the hospitalization	
	The facility complied with any additional elements required by VHA or local policy.	

MH RRTP

The purpose of this review was to determine whether the facility's Domiciliary Care for Homeless Veterans Program complied with selected EOC requirements.[7]

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program, and conversed with key employees. The table below shows the areas reviewed for this topic. Items that did not apply to this facility are marked "NA." The facility generally met requirements. We made no recommendations.

NC	Areas Reviewed	Findings
	The residential environment was clean and in good repair.	
	Appropriate fire extinguishers were available near grease producing cooking devices.	
	There were policies/procedures that addressed safe medication management and contraband detection.	
	Monthly MH RRTP self-inspections were conducted, documented, and included all required elements, work orders were submitted for items needing repair, and any identified deficiencies were corrected.	
	Contraband inspections, staff rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications were conducted and documented.	
	Written agreements acknowledging resident responsibility for medication security were in place.	
	The main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	
	Closed circuit television monitors with recording capability were installed in public areas but not in treatment areas or private spaces, and there was signage alerting veterans and visitors that they were being recorded.	
	There was a process for responding to behavioral health and medical emergencies, and staff were able to articulate the process(es).	
	In mixed gender units, women veterans' rooms were equipped with keyless entry or door locks, and bathrooms were equipped with door locks.	

NC	Areas Reviewed (continued)	Findings
	Medications in resident rooms were secured.	
	The facility complied with any additional elements required by VHA or local policy.	

Facility Profile (Anchorage/463) FY 2012[c]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	$163.0
Number of:	
• **Unique Patients**	18,557
• **Outpatient Visits**	172,352
• **Unique Employees**[d]	414
Type and Number of Operating Beds: (through August 2012)	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	50
Average Daily Census:	
• **Hospital**	NA
• **CLC**	NA
• **Mental Health**	27
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Fairbanks/463GA Kenai/463GB Mat-Su/463GC
VISN Number	20

[c] All data is for FY 2012 except where noted.
[d] Unique employees involved in direct medical care (cost center 8200).

VHA Patient Satisfaction Survey

VHA has identified patient satisfaction scores as significant indicators of facility performance. Patients are surveyed monthly. Table 1 below shows facility, VISN, and VHA overall inpatient and outpatient satisfaction scores for FY 2012.

Table 1

	Inpatient Scores		Outpatient Scores			
	FY 2012		FY 2012			
	Inpatient Score Quarters 1–2	Inpatient Score Quarters 3–4	Outpatient Score Quarter 1	Outpatient Score Quarter 2	Outpatient Score Quarter 3	Outpatient Score Quarter 4
Facility	*	*	48.2	50.5	54.2	50.3
VISN	65.3	65.3	51.5	49.3	49.9	49.8
VHA	63.9	65.0	55.0	54.7	54.3	55.0

*The facility does not have inpatient beds.

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 15, 2013

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Alaska VA Healthcare System, Anchorage, AK**

To: Director, Seattle Office of Healthcare Inspections (54SE)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. Thank you for the opportunity to provide a status report on follow-up to the findings from the Combined Assessment Program Review of the Alaska VA Healthcare System, Anchorage, AK.

2. Attached please find the facility concurrence and response to the finding from the review.

3. If you have additional questions or need further information, please contact Susan Gilbert, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: May 23, 2013

From: Director, Alaska VA Healthcare System (463/00)

Subject: **CAP Review of the Alaska VA Healthcare System, Anchorage, AK**

To: Director, Northwest Network (10N20)

1. The findings from the Alaska VA Healthcare System Combined Assessment Program (CAP) review by the Office of the Inspector General (OIG) conducted March 25, through March 28, 2013 have been reviewed.

2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have been completed.

(original signed by:)
Susan M. Yeager, MS
Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that processes be strengthened to ensure that actions from peer reviews are completed and reported to the PRC.

Concur

Target date for completion: September 1, 2013

Facility response: The peer review processes have been strengthened to ensure action items from peer reviews are completed and reported to the Peer Review Committee (PRC). We will monitor the PRC to ensure that all actions from peer reviews are tracked to completion.

Recommendation 2. We recommended that processes be strengthened to ensure that FPPEs for newly hired licensed independent practitioners are consistently initiated and that results are consistently reported to the MEC.

Concur

Target date for completion: September 1, 2013

Facility response: A tracking spreadsheet has been developed to be maintained by the Credentialing Manager on a monthly basis. FPPE results will be reported to the MEC and the tracking spreadsheet indicates whether FPPE will be continued or if the provider will transition to OPPE. We will monitor the FPPE process to ensure FPPEs are consistently initiated for all new providers and that FPPE results are reported to the MEC.

Recommendation 3. We recommended that processes be strengthened to ensure that the quality of entries in the EHR is reviewed.

Concur

Target date for completion: September 1, 2013

Facility response: A work group evaluated our monitoring process against Joint Commission and VA standards used by each of the clinical services for medical record review. We clarified the elements used during the auditing process to ensure information is present, accurate, legible, authenticated and completed on time. Analysis of outcomes, discussions and corrective actions are documented in the Medical Records Committee (MRC) minutes. The chair of the MRC reports results to the

Medical Executive Board on a quarterly basis. The reporting process was strengthened by providing additional administrative support to ensure minutes are completed timely, accurately, and routed appropriately. Review teams are monitoring both clinical and administrative aspects of care.

Recommendation 4. We recommended that processes be strengthened to ensure that quarterly trend reports summarize any discrepancies and problematic trends and identify potential areas for improvement.

Concur

Target date for completion: September 1, 2013

Facility response: Beginning with the 3rd Qtr FY13 report, the Controlled Substance Inspection (CSI) Quarterly Trend Reports will be done in a narrative format in addition to the current graph and table format. Narrative reports will clearly summarize discrepancies and problematic trends, as well as potential areas for improvement. We will monitor quarterly trend reports to ensure that any discrepancies and problematic trends and potential areas for improvement are identified.

Recommendation 5. We recommended that processes be strengthened to ensure that CS inspectors receive annual updates and refresher training regarding problematic issues identified through external survey findings and other quality control measures.

Concur

Target date for completion: June 30, 2013

Facility response: The annual controlled substance inspector update and refresher training will be completed by June 2013. This training will be tracked in TMS to ensure all CS inspectors complete the required annual refresher training.

Recommendation 6. We recommended that processes be strengthened to ensure that local policy related to the return of "Green Sheets" to the pharmacy is adhered to and that all elements required for the processing of prescriptions are present.

Concur

Target date for completion: September 1, 2013

Facility response: The Chief of Pharmacy has reviewed and revised the policy related to the return of "Green Sheets." The "Green Sheets" are no longer batched and addressed on a weekly basis, they are addressed as they are returned to the pharmacy on a daily basis. The Chief of Pharmacy is monitoring to ensure that policy is adhered to. The presence of elements required for the processing of prescriptions are verified during monthly Controlled Substance Inspections and via review when Green Sheets are returned from the Narcotic Area of Use (NAOU). These elements include patient identifiers, date of administration, amount of medication administered, and signature of

the staff that administered it. When there is wastage of controlled substances, it will be annotated on the Green Sheet and accompanied by two signatures.

Recommendation 7. We recommended that processes be strengthened to ensure that documentation of CS inspector orientation, training, annual updates, and annual competency assessments are maintained.

Concur

Target date for completion: September 30, 2013

Facility response: The annual update will be completed in June 2013. New CSI's will be appointed, oriented, and trained in 4th Quarter FY13. Training will be documented in TMS. Competency will be documented and maintained both in the employee's competency folder and by the CSI coordinator.

Recommendation 8. We recommended that processes be strengthened to ensure that CS inspectors initial and date CS Inspecting Official Checklists, VA CS forms, and pharmacy activity logs.

Concur

Target date for completion: September 30, 2013

Facility response: The inspection checklist has been modified to include instructions to initial and date each item as they are completed. Pharmacy vault inventories are currently signed by the inspectors. The CSI coordinator will monitor all CSI checklists and pharmacy vault inventories to ensure the inspectors initial and date all forms.

Recommendation 9. We recommended that a process be established to track HPC consults that are not acted upon within 7 days of the request.

Concur

Target date for completion: September 1, 2013

Facility response: A consult timeliness monitor for HPC was established on the organization dashboard. The consult manager enters data monthly and communicates findings to the Home Based Primary Care manager for any needed corrective action. These results are reported to the medical record committee quarterly. A review cycle has been established to ensure that all appropriate consult services are being monitored.

Recommendation 10. We recommended that processes be strengthened to ensure that the COS reviews HRCP activities in a timely manner.

Concur

Target date for completion: September 1, 2013

Facility response: The AVAHS has strengthened processes to ensure the COS reviews the activities of the Home Respiratory Care Program. The Home Respiratory Care Committee minutes will be reviewed and signed by the COS for concurrence within two weeks of the meeting. The HRCP committee chair will monitor for compliance.

Recommendation 11. We recommended that processes be strengthened to ensure that high-risk home oxygen patients are identified.

Concur

Target date for completion: September 1, 2013

Facility response: We will develop high-risk criteria that will include patients who smoke. The referring clinician will indicate if the patient is high-risk on the consult for home oxygen. The Home Oxygen Coordinator or the Respiratory Practitioner will inform the contracted home oxygen vendor when a patient is at high-risk status for smoking while oxygen is in use. A list of high-risk patients will be maintained and Home Oxygen Coordinator the will track the list for patient follow-up and education and will report to the Home Respiratory Care Committee.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. Senate: Mark Begich, Lisa Murkowski
U.S. House of Representatives: Don Young

This report is available at www.va.gov/oig.

Endnotes

[1] References used for this topic included:
- VHA Directive 2009-043, *Quality Management System*, September 11, 2009.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-017, *Prevention of Retained Surgical Items*, April 12, 2010.
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