Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-05249-162

Healthcare Inspection

Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska

March 9, 2017

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Lisa Murkowski to follow up on recommendations we made in the published report, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska,* (Report No. 14-04077-405, July 7, 2015). We evaluated selected aspects of the progress the Alaska VA Healthcare System (system) made in implementing the action plans outlined in the prior report and reviewed access to care data for patients at all system community based outpatient clinics.

In response to recommendations in the 2015 report, we found that a permanent provider had been in place at the Mat-Su VA Community Based Outpatient Clinic since September 2014 and that system leaders had developed a recruitment and retention plan. Improvements were made to contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events. Training requirements regarding care coordination were implemented in all community based outpatient clinics and primary care settings.

We determined that overall access to care throughout the system met Veterans Health Administration (VHA) performance measure targets based on data maintained by VHA and provider recommendations for new and established primary care patients. The system made improvements to the peer review process and completed the planned actions for the nine patient cases identified in the 2015 report.

We found that managers continued to monitor provider evaluations and implement enhancements needed for committee reporting. System leaders continued to implement actions to improve culture and morale throughout the system.

Based on actions already implemented, recommendations 3 and 6 from the 2015 report are considered closed. The remaining seven recommendations will remain open for continued monitoring of actions by the OIG Follow-Up Staff. We made no new recommendations.

OIG Update: Based on updated information provided to us in May 2016, we determined the planned actions have been completed for the remaining seven recommendations and consider all nine original recommendations closed.

Comments

The Veterans Integrated Service Network and System Directors concurred with the findings and recommendations and provided acceptable action plans. (See Appendixes B and C, pages 16–17 for the Directors' comments.) **OIG Update**: Based on updated information received in May 2016, all recommendations are considered closed and no further action is required.

JOHN D. DAIGH, JR., M.D.
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Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Senator Lisa Murkowski to follow up on a prior report of the Alaska VA Healthcare System (system), Anchorage, AK, and to review access to care for patients at all system community based outpatient clinics (CBOCs).

Background

The system serves veterans throughout the State of Alaska and is part of Veterans Integrated Service Network (VISN) 20. Primary, specialty, and mental health outpatient care are provided through the parent outpatient clinic located in Anchorage as well as CBOCs in Fairbanks, Juneau, Kenai, and Wasilla (this CBOC is called Mat-Su due to its location in the Matanuska-Susitna Valley) and an outpatient clinic in Homer. Inpatient services are provided through a joint venture with Joint Base Elmendorf-Richardson located adjacent to the Anchorage clinic, as well as through purchased care (formerly known as fee basis care) with community hospitals.

Scope and Methodology

We conducted the review between July 7, 2015 and December 31, 2015. The system provided updates on July 8, 2016. The scope of our inspection was the review of actions taken in response to the nine recommendations in the OIG report *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska,* (Report No. 14-04077-405, July 7, 2015)[1] and to review access to care for patients at all CBOC sites. We reviewed provider staffing, veteran wait times, and access performance measures maintained by VHA from October 1, 2014 through September 30, 2015.

We reviewed extensive documentation including Veterans Health Administration (VHA) handbooks and directives; system policies and procedures; quality management and staffing documents; scheduling, access, and performance data; committee minutes; patient incident reports; patient complaints; results of the June 2015 OIG Employee Assessment Review survey as well as the 2014 and 2015 VHA All Employee Surveys.

We conducted a site visit to the Anchorage outpatient clinic September 22–25, 2015. We interviewed the Interim Director, Associate Director, Chief of Staff, and Chief of Quality Management. We also conducted interviews with directors, mid-level managers, providers, and other clinical and administrative staff knowledgeable about quality, scheduling, staffing, and access to care processes.

[1] VA Office of Inspector General, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, AK,* Report No. 14-04077-405, July 7, 2015.

We conducted a site visit to the CBOCs in Fairbanks, Kenai, and Wasilla, AK, October 20–22, 2015. We interviewed nurse managers, providers, and other clinical and administrative staff knowledgeable about scheduling, staffing, and access to care in the CBOC environment.

We conducted a site visit to the Juneau CBOC November 17, 2015. We interviewed the nurse manager, provider, and other clinical and administrative staff knowledgeable about scheduling, staffing, and access to care in the CBOC environment.

We also performed a follow-up visit with Anchorage leaders December 10–11, 2015. We interviewed the Interim Director, Associate Director, Chief of Staff, and Chief of Human Resources (HR).

VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 cited in this report expired June 30, 2015. We considered the policy to be in effect as it had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[2] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[3] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[4]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

[2] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016.
[3] VA Under Secretary for Health Memorandum. *Validity of VHA Policy Document*, June 29, 2016.
[4] Ibid.

Inspection Results

We assessed the nine recommendations from *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska*, (Report No. 14-04077-405, July 7, 2015)[5] for implementation of action plans.

1. Mat-Su VA CBOC Access to Care

In our 2015 report, we recommended the VISN Director ensure that the System Director implement an action plan based on ongoing monitoring of access performance measures that included recruitment and retention and ensured continued provision of primary care by a permanent provider at the Mat-Su VA CBOC.

In response to the 2015 report, system leaders stated it had a permanent provider at the Mat-Su VA CBOC. Access performance measures are monitored at the service and executive levels and are reported monthly at Quality and Executive Committee meetings. For the Mat-Su VA CBOC specifically, demand for new patient primary care appointments was met within 14 days of the preferred date 100 percent of the time, and demand for established patient primary care appointments was met within 14 days of the preferred date 93 percent of the time. (See Table 1 in Appendix A.) Access to care was maintained by utilizing a telehealth[6] provider located at the Boise VA Medical Center and referring patients for care in the community through the Southcentral Foundation.[7]

HR staff continued to report difficulty in attracting and retaining qualified candidates to the remote CBOC sites. To help attract applicants, HR leaders were given local approval authority from VISN 20 leaders for recruitment, relocation, and retention incentives of up to 15 percent of annual pay. Incentives in excess of 15 percent were considered on a case-by-case basis and required VISN approval. System leaders also requested local authority to approve guaranteed home buyouts for physicians at those sites through the VHA home buyout program. However, the home buyout program for physicians was discontinued nationally at the end of fiscal year (FY) 2015. System and HR Leaders continued to discuss provider recruitment and proposed actions in July 2015, and implementation of the actions is ongoing.

[5] VA Office of Inspector General, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, AK*, Report No. 14-04077-405, July 7, 2015.

[6] Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and wireless communications. www.healthit.gov/providers-professionals/faws/what-telehealth-how-teleheatlh-different-telemedicine. Accessed January 5, 2016, last updated March 21, 2014.

[7] Southcentral Foundation is an Alaska Native-owned, nonprofit health care organization serving nearly 65,000 Alaska Native and American Indian people living in Anchorage, Matanuska-Susitna Valley, and 55 rural villages.

The Mat-Su VA CBOC was staffed with a full-time primary care advanced practice provider[8] who started in October 2015. The previous advanced practice provider worked at the clinic from December 2013 to October 2015. As of December 2015, a vacancy remained for one primary care physician. The Mat-Su VA CBOC was utilizing a primary care telehealth provider supported by the Boise VA Medical Center to help manage patients and provide continuity of care.

OIG Update: In May 2016, OIG received evidence of ongoing approval to use recruitment and retention incentives, access standards for new and established patients being met for more than six consecutive months, and the names of two primary care providers assigned to the Mat-Su CBOC. Based on the updated information, we determined the planned actions have been completed for Recommendation 1 and we consider this recommendation closed.

2. Continuity of Care

In our 2015 report, we recommended that the VISN Director ensure that the System Director implement contingency plans for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events as required by VHA policy.

In response to the 2015 report, system leaders stated a detailed written plan would be developed no later than May 31, 2015, to ensure appropriate documentation exists to support continuity of care and access during staff shortages.

We found that a Primary Care Contingency Plan had been developed, but at the time of the onsite visit in September 2015, the plan remained in the draft phase. However, portions of the Primary Care Contingency Plan were starting to be implemented, including the use of surrogate[9] providers, to cover unexpected provider absences and a float provider was going to the Mat-Su VA CBOC each week.

OIG Update: In May 2016, we received evidence of full implementation of the Primary Care Contingency Plan. Based on the updated information, we determined the planned actions have been completed for Recommendation 2 and we consider this recommendation closed.

[8] Advanced practice providers are nurse practitioners and physician assistants who provide care and treatment while working under the close supervision of a physician. They have been certified to perform many of the same tasks as a physician.

[9] Surrogate providers are primary care healthcare providers who, in the event of an unexpected provider absence, review the records of the patients that are to be rescheduled to ensure urgent medical problems are addressed in a timely fashion, provisions are made for necessary medication renewals, and patients are rescheduled to be seen on a clinically-appropriate basis.

3. Patient-Aligned Care Teams

In our 2015 report, we recommended that the VISN Director ensure that the System Director implement the requirements of VHA Handbook 1101.10, *Patient-Aligned Care Teams*, regarding care coordination.[10]

In response to the 2015 report, system leaders reported the creation of a standardized training program that included patient centered care, access, care coordination, and use of a standardized lesson plan. Training for staff at the Mat-Su VA CBOC occurred April 27–28, 2015. In addition, the clinic's care management tool, used to electronically track high-risk patients in need of follow-up, was deployed to Mat-Su VA CBOC staff in February 2015.

Onsite education was provided for all Primary Care staff from March through July 2015.

We consider the original Recommendation 3 closed.

4. CBOC Access to Care

In our 2015 report, we recommended that the VISN Director ensure that the System Director provide access to care at the Mat-Su VA CBOC in accordance with VHA policy and provider recommendations for follow-up.

At the request of Senator Murkowski, we expanded the scope of our follow-up review to include access to care at all CBOCs within the system.

The system met access to care measures in FY 2015 for new and established primary care patients by utilizing Department of Defense sharing contracts, Non-VA Care Coordination, and community partnerships for care within the various CBOC communities.

Fairbanks VA CBOC

The Fairbanks VA CBOC had one full-time advanced practice provider and a vacancy for a full-time physician. In the first half of FY 2015 (October 2014 through March 2015), newly enrolled patients did not wait more than 30 days for primary care appointments. During the second half of FY 2015 (April through September 2015), an average of 17 percent of the newly enrolled patients waited more than 30 days from their preferred dates for an initial appointment. An average of four percent of the established patients waited more than 30 days from their preferred dates for appointments in FY 2015. (See Table 2 in Appendix A.) The delays were due, in part, to the CBOC losing a provider during this time. This loss was managed by bringing in two intermittent providers. Efforts to actively hire a second provider were in process at the time of this review.

[10] VHA Handbook 1101.10, *Patient Aligned Care Team (PACT) Handbook*, February 5, 2014.

Kenai VA CBOC

The Kenai VA CBOC had one full-time physician provider and one full-time advanced practice provider. Patients newly enrolled in FY 2015 did not wait more than 30 days from their preferred dates for scheduled appointments. Less than one percent of established patients waited more than 30 days for a primary care appointment during the same time period. (See Table 3 in Appendix A.)

Juneau VA CBOC

The Juneau VA CBOC had one full-time physician provider. New and established primary care patients in FY 2015 did not wait more than 30 days from their preferred dates for scheduled appointments. (See Table 4 in Appendix A.)

OIG Update: Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 4 and we consider this recommendation closed.

5. Peer Review

In our 2015 report, we recommended that the VISN Director ensure that the System Director implement a peer review process consistent with VHA policy.

In response to the 2015 report, system leaders stated corrective actions would be implemented to ensure compliance with VHA Directive 2010-025, *Peer Review for Quality Management*, and that the process would be monitored to ensure compliance.[11] The target date for completion was August 31, 2015. System and clinical leaders implemented planned actions and made improvements to the peer review process.

OIG Update: Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 5 and we consider this recommendation closed.

6. Evaluation and Follow-Up of Patient Cases

In our 2015 report, we recommended that the VISN Director ensure that the System Director perform peer reviews and consult regional counsel as appropriate for the nine cases identified in the report.

System leaders reported that the nine cases would be processed through external reviews and that any findings would be addressed upon completion of the reviews. The target date set for completion was August 31, 2015. Clinical leaders completed the planned actions for all nine cases.

[11] VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This VHA Directive expired June 30, 2015 and has not been updated.

We consider the original Recommendation 6 closed.

7. Provider Evaluations

In our 2015 report, we recommended that the VISN Director ensure that the System Director implement a provider evaluation process consistent with VHA policy.

System leaders reported implementing a provider evaluation process in accordance with VHA Handbook 1100.19, *Credentialing and Privileging*, and stated that the process would be monitored to ensure compliance.[12] A date for completion was set for December 31, 2015.

The Credentialing Manager created a Focused Professional Practice Evaluation (FPPE) tracker (a spreadsheet) and Ongoing Professional Practice Evaluation (OPPE) signature table to monitor timeliness and completion of provider evaluations.[13,14] These tools are used to more easily monitor the initial dates, due dates, and actions supporting the FPPE and OPPE processes. The FPPE tracker had been used intermittently since 2013 but used consistently since April 2015. The OPPE signature table was initiated in March 2015. We could not fully evaluate whether these tools were consistently effective in assisting the Credentialing Office to monitor timeliness, as not enough time had elapsed since implementation.

Credentialing staff have been using PRIVplus™ software to enhance evaluation tracking since November 2014; PRIVplus generates auto-alerts of impending due dates. Provider evaluation renewals were monitored for timeliness through special report functionality.[15]

The original report identified that a shortage of credentialing personnel contributed to delays in the timely processing of FPPEs and OPPEs. Additionally, while provider evaluation data was being collected at the service level, Service Chiefs were not consistently reporting the data timely, leading to a lack of discussion and reporting of FPPEs and OPPEs at the Executive Committee of the Medical Staff in FY 2014 and FY 2015. Executive Committee of the Medical Staff minutes from October and November 2015 demonstrated discussion, action, and tracking of FPPEs. However, as OPPEs are on a 6-month cycle with Executive Committee of the Medical Staff action in August and February, additional time is needed to determine whether the oversight committee is monitoring the provider evaluation process.

[12] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
[13] A Focused Professional Practice Evaluation is for a limited period of time and may include direct supervision, or proctoring, by an appropriately-privileged practitioner. It is required for practitioners new to the facility, practitioners already appointed at the facility who are requesting new privileges, for practitioners who have had a lapse in clinical activity or for those procedures that are high risk as defined by medical facility policy.
[14] An Ongoing Professional Practice Evaluation is on-going monitoring of privileged practitioners, which allows the facility to identify professional practice trends that impact the quality of care and patient safety.
[15] PRIVplus is web-based credentialing and privileging software for healthcare providers that tracks all aspects of the credentialing and privileging assignment process from start to finish.

OIG Update: In May 2016, OIG received evidence of timely processing for 93 percent of the semi-annual OPPE's. Based on the updated information, we determined the planned actions have been completed for Recommendation 7 and we consider this recommendation closed.

8. Committee Reporting

In our 2015 report, we recommended that the VISN Director ensure that the System Director strengthen processes for committee reporting to align with VHA Directive 1026, *Enterprise Framework for Quality, Safety, and Value*,[16] and system bylaws.

Senior managers conducted an organizational review of committee meeting minutes, system bylaws, and VHA Directive 1026.[17] The policy for managing committee meeting minutes was revised in May 2015,[18] and staff training was initiated to introduce changes and expectations. Training sessions on committee reporting and strengthening of documentation in minutes occurred June through October 2015; training continues upon request on a one-on-one basis.

The target date for updating system bylaws had been set for December 31, 2015. The bylaws were rewritten and routed for approval December 30, 2015, with a plan to discuss the updates at the January Medical Executive Board meeting.

At the end of 2015, an electronic routing and approval process to improve tracking and reduce routing time was being tested. Capturing discussions and decisions in committee minutes continues to be an area that Quality Management focuses on in its System Redesign and Performance Improvement work.

OIG Update: Meeting minutes provided by the system in May 2016 demonstrated improved content and a process for tracking sustainment over time. Based on the updated information, we determined the planned actions have been completed for Recommendation 8 and we consider this recommendation closed.

9. *Culture, Morale, and Leadership*

In our 2015 report, we recommended that the VISN Director ensure that the System Director assess the culture, morale, and leadership issues, and take appropriate action as necessary.

We were onsite to interview staff for the present review 6 months following the issuance to VHA of the draft original report and 3 months after the final publication of the original report. Two of the four members of the executive leadership team in place at the time of our 2015 report no longer worked at the organization, and a third member had

[16] VHA Directive 1026, *Enterprise Framework for Quality, Safety and Value*, August 2, 2013.
[17] Ibid.
[18] Alaska VA Healthcare System Numbered Memorandum 00-22, *Policy on Committee Meeting Minutes*, May 15, 2015.

changed roles within the leadership team at the time of our follow-up visit. The current executive leadership team had been in place since August 2015.

During the present review, we determined that actions were taken to assess the culture and morale at the Mat-Su VA CBOC, and a plan was implemented to provide ongoing support and monitoring of this CBOC.

We found that current executive leaders were aware of staff concerns regarding lack of transparency and guidance and had taken action to improve communication with managers and staff across the system. In December 2015, the executive leadership team joined with front-line managers to initiate strategic planning and implement VHA's Leaders Developing Leaders program.

While some staff continued to express a lack of trust and confidence in the executive leadership team, we found the leadership team to be making appropriate efforts to improve communication and relationships across the system's multiple sites such as the use of the Director's Communication Update emails and hosting town hall meetings.

At the time of our original report in 2015, and during the present review, staff conveyed that HR errors and delays contributed to their workplace dissatisfaction. The system contracted with an external consulting firm to conduct a thorough analysis of HR operations and suggest corrective actions. An internal review by VHA was also completed in October 2015. Since the time of the onsite visits made as part of the original report, executive leaders selected and hired a permanent HR Officer who was actively implementing process improvements in alignment with recommendations from VHA and the external consultant.

Communication between executive leaders and front-line managers regarding the rationale behind position management decisions remains an ongoing challenge. We confirmed that managers have access to the HR staffing dashboard that provides some information regarding pending recruitments. We found opportunities remain to educate managers and staff in the alignment of hiring priorities and budgetary limitations.

We found that positive changes have been made to the organizational leadership structure of primary care. A new, permanent nurse manager was hired in November 2014 at the Mat-Su VA CBOC, and an Associate Chief Nurse for Primary Care was hired in February 2015. The Associate Chief Nurse for Primary Care had been instrumental in providing a bridge between CBOC staff and system leaders that included the establishment of routine meetings with CBOC nurse managers onsite in Anchorage and CBOC nurse manager participation in the Leaders Developing Leaders Program.

OIG Update: Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 9 and we consider this recommendation closed.

Conclusions

We determined that a permanent provider had been in place at the Mat-Su VA CBOC since September 2014 and that two providers were permanently assigned to the CBOC as of April 2016. A provider recruitment and retention plan had been developed and implemented. **OIG Update**: Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 1 and we consider this recommendation closed.

We determined that improvements to contingency plans have been made for ensuring patients receive continuity of and access to appropriate primary care during periods of inadequate resources, extended staff absences, staff turnover, understaffing, and nature-related events. **OIG Update:** Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 2 and we consider this recommendation closed.

We determined that training requirements of VHA Handbook 1101.10, *Patient-Aligned Care Teams*, regarding care coordination had been implemented in all CBOCs and Primary Care settings.[19] The original Recommendation 3 is considered closed.

Access to care throughout the system met VHA performance measure targets based on data maintained by VHA and provider recommendations for new and established primary care patients. However, accessibility had decreased at the Fairbanks VA CBOC. **OIG Update:** Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 4 and we consider this recommendation closed.

The system had made improvements to the peer review process. **OIG Update:** Based on information provided to us in May 2016, we determined the planned actions had been completed for Recommendation 5 and we consider this recommendation closed.

The system completed the planned actions for the nine patient cases from the 2015 report. The original Recommendation 6 is considered closed.

We determined that provider evaluations and the monitoring of provider evaluations remained an area of focus. **OIG Update:** Based on updated information provided to us in May 2016, we determined the planned actions have been completed for Recommendation 7 and we consider this recommendation closed.

The enhancements needed for committee reporting impacted many committees within the system. Updated information provided to OIG demonstrated that the policy for managing committee meeting minutes was revised and updates to system bylaws were completed. **OIG Update:** Based on updated information provided to us in May 2016,

[19] VHA Handbook 1101.10, *Patient-Aligned Care Teams*, February 5, 2014.

we determined the planned actions have been completed for Recommendation 8 and we consider this recommendation closed.

Executive leaders continued to implement actions to improve culture and morale issues throughout the system. The current executive leadership team was newly formed and will require additional time to develop confidence and trust with staff. The executive leadership team was aware of problems occurring in the HR Service and was taking action to reduce errors and delays. **OIG Update:** Based on information provided to us in May 2016, we determined the planned actions had been completed for Recommendation 9 and we consider this recommendation closed.

We made no new recommendations.

Appendix A

CBOC Access to Care Tables

Table 1. New and Established Primary Care Patient Wait Times for Mat-Su VA CBOC FY 2015

Month FY 2015	New Patient Appointments Excluding C&P and DES Appointments	New Patient Appointments Greater Than 30 Days from Preferred Date	New Patient Wait Greater Than 30 Days from Preferred Date	Established Patient Appointments	Established Patient Appointments Greater Than 30 Days from Preferred Date	Established Patient Wait Greater Than 30 Days from Preferred Date
OCT	9	0	0.00%	201	3	1.49%
NOV	2	0	0.00%	184	1	0.54%
DEC	4	0	0.00%	304	1	0.33%
JAN	5	0	0.00%	326	0	0.00%
FEB	2	0	0.00%	269	1	0.37%
MAR	3	0	0.00%	287	4	1.39%
APR	6	0	0.00%	374	3	0.80%
MAY	3	0	0.00%	322	0	0.00%
JUN	6	0	0.00%	336	0	0.00%
JUL	5	0	0.00%	328	0	0.00%
AUG	4	0	0.00%	300	0	0.00%
SEP	22	0	0.00%	225	2	0.89%

Source: VA OIG via VHA Support Service Center[20]

C&P = Compensation and Pension; DES = Disability Evaluation System

[20] *Wait Times and Wait List Reports*. https://vssc.med.va.gov/products.asp?PgmArea=12 https://vssc.med.va.gov/products.asp?PgmArea=12. Accessed November 27, 2015. The VHA Support Service Center, an internal VA Web site that is not available to the public, provides data to internal VA organizations/program offices for the purpose of health care, delivery, analysis, and evaluation.

Table 2. New and Established Primary Care Patient Wait Times for Fairbanks VA CBOC FY 2015

Month FY 2015	New Patient Appointments Excluding C&P and DES Appointments	New Patient Appointments Greater Than 30 Days from Preferred Date	New Patient Wait Greater Than 30 Days from Preferred Date	Established Patient Appointments	Established Patient Appointments Greater Than 30 Days from Preferred Date	Established Patient Wait Greater Than 30 Days from Preferred Date
OCT	4	0	0.00%	381	3	0.79%
NOV	11	0	0.00%	347	8	2.31%
DEC	34	0	0.00%	349	0	0.00%
JAN	24	0	0.00%	322	0	0.00%
FEB	17	0	0.00%	309	3	0.97%
MAR	8	0	0.00%	216	12	5.56%
APR	7	1	14.29%	321	21	6.54%
MAY	4	1	25.00%	284	18	6.34%
JUN	7	1	14.29%	309	29	9.39%
JUL	21	7	33.33%	278	44	15.83%
AUG	23	1	4.35%	307	7	2.28%
SEP	36	4	11.11%	282	10	3.55%

Source: VA OIG via VHA Support Service Center[21]

C&P = Compensation and Pension; DES = Disability Evaluation System

[21] *Wait Times and Wait List Reports*. https://vssc.med.va.gov/products.asp?PgmArea=12 https://vssc.med.va.gov/products.asp?PgmArea=12. Accessed November 27, 2015. The VHA Support Service Center, an internal VA Web site that is not available to the public, provides data to internal VA organizations/program offices for the purpose of health care, delivery, analysis, and evaluation.

Table 3. New and Established Primary Care Patient Wait Times for Kenai VA CBOC FY 2015

Month FY 2015	New Patient Appointments Excluding C&P and DES Appointments	New Patient Appointments Greater Than 30 Days from Preferred Date	New Patient Wait Greater Than 30 Days from Preferred Date	Established Patient Appointments	Established Patient Appointments Greater Than 30 Days from Preferred Date	Established Patient Wait Greater Than 30 Days from Preferred Date
OCT	27	0	0.00%	698	17	2.44%
NOV	17	0	0.00%	475	4	0.84%
DEC	18	0	0.00%	444	1	0.23%
JAN	18	0	0.00%	470	0	0.00%
FEB	22	0	0.00%	480	1	0.21%
MAR	16	0	0.00%	463	0	0.00%
APR	20	0	0.00%	475	2	0.42%
MAY	21	0	0.00%	460	1	0.22%
JUN	31	0	0.00%	482	0	0.00%
JUL	24	0	0.00%	416	0	0.00%
AUG	27	0	0.00%	456	0	0.00%
SEP	24	0	0.00%	463	1	0.22%

Source: VA OIG via VHA Support Service Center[22]

C&P = Compensation and Pension; DES = Disability Evaluation System

[22] *Wait Times and Wait List Reports*. https://vssc.med.va.gov/products.asp?PgmArea=12 https://vssc.med.va.gov/products.asp?PgmArea=12. Accessed November 27, 2015. The VHA Support Service Center, an internal VA Web site that is not available to the public, provides data to internal VA organizations/program offices for the purpose of health care, delivery, analysis, and evaluation.

Table 4. New and Established Primary Care Patient Wait Times for Juneau VA CBOC FY 2015

Month FY 2015	New Patient Appointments Excluding C&P and DES Appointments	New Patient Appointments Greater Than 30 Days from Preferred Date	New Patient Wait Greater Than 30 Days from Preferred Date	Established Patient Appointments	Established Patient Appointments Greater Than 30 Days from Preferred Date	Established Patient Wait Greater Than 30 Days from Preferred Date
OCT	4	0	0.00%	110	0	0.00%
NOV	2	0	0.00%	95	0	0.00%
DEC	5	0	0.00%	96	0	0.00%
JAN	1	0	0.00%	97	0	0.00%
FEB	1	0	0.00%	94	0	0.00%
MAR	5	0	0.00%	93	0	0.00%
APR	5	0	0.00%	110	0	0.00%
MAY	2	0	0.00%	80	0	0.00%
JUN	3	0	0.00%	91	0	0.00%
JUL	13	0	0.00%	89	0	0.00%
AUG	14	0	0.00%	90	0	0.00%
SEP	11	0	0.00%	76	0	0.00%

Source: VA OIG via VHA Support Service Center[23]

C&P = Compensation and Pension; DES = Disability Evaluation System

[23] *Wait Times and Wait List Reports*. https://vssc.med.va.gov/products.asp?PgmArea=12 https://vssc.med.va.gov/products.asp?PgmArea=12. Accessed November 27, 2015. The VHA Support Service Center, an internal VA Web site that is not available to the public, provides data to internal VA organizations/program offices for the purpose of health care, delivery, analysis, and evaluation.

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 2, 2016

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

Subj: Healthcare Inspection—Follow-Up of Scheduling, Staffing, and Quality of Care Concerns, Alaska VA Healthcare System, Anchorage, Alaska

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

Thank you for the opportunity to review and concur with the report: Follow-up of Scheduling, Staffing, and Quality of Care Concerns, Alaska VA Healthcare System, Anchorage, Alaska.

(*original signed by:)*
Michael J. Murphy

Appendix C

System Director Comments

Department of Veterans Affairs

Memorandum

Date: May 6, 2016

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

Subj: Healthcare Inspection—Follow-Up of Scheduling, Staffing, and Quality of Care Concerns, Alaska VA Healthcare System, Anchorage, Alaska

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

I have reviewed the draft report Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System, Anchorage, Alaska and found it to be accurate. I have no recommended changes or additional comments.

(o*riginal signed by:)*
Linda L. Boyle, DM, MSN, RN
Interim Director

Appendix D

OIG Contact and Staff Acknowledgments

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Appendix E

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