



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Alaska VA
Healthcare System
Anchorage, Alaska



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Figure 1. Alaska VA Healthcare System, Anchorage, AK (Source: <https://vaww.va.gov/directory/guide/>, accessed on September 17, 2019)

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Alaska VA Healthcare System (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The inspections are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the inspection, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes¹ (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of July 22, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help this facility and

¹ The OIG's review of the emergency department and urgent care center (UCC) operations and management focused on the clinical risks of the emergency department/UCC areas. This review was not performed at the Alaska VA Healthcare System because the facility did not have an emergency department or UCC.

other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, chief of staff, associate director for Patient Care Services/chief nurse executive (ADPCS), and associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Council having oversight for several working groups. The quality manager was the chair and the director served as the co-chair of the Quality Board, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The facility's leadership team had been working together for 23 months, although the chief of staff had served in the position since May 1998. The director and ADPCS were permanently assigned in July 2016 and April 2017, respectively. The associate director was permanently assigned in August 2017.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders were engaged and promoted a culture of safety where employees feel safe bringing forward issues and concerns. The selected patient experience survey scores applicable to facility leaders were better than the VHA average, and facility leaders had implemented processes and plans to maintain positive patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,² disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors. At the time of the on-site visit, the facility had closed all recommendations for improvement.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities

² The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

and differences between the top and bottom performers” within VHA.³ Although the leadership team members were knowledgeable within their areas of responsibility about selected SAIL metrics, the leaders should continue to take actions to sustain and improve performance on the quality of care metrics and measures likely contributing to the facility’s SAIL “3-star” quality ratings.⁴

The OIG noted deficiencies in five of the seven clinical areas reviewed and issued six recommendations that are attributable to the director and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with requirements for protected peer reviews. However, the OIG identified noncompliance with completing the minimum number of root cause analyses.

Medication Management

The facility complied with requirements for most of the performance indicators evaluated, including controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and non-pharmacy and pharmacy area inspections. However, the OIG identified noncompliance with the review of override reports.

Mental Health

The OIG also found the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator, tracking of MST-related data, and provision of clinical care. However, the OIG noted a concern with the completion of MST mandatory training.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and validating patient and/or caregiver understanding when education was provided. However, the OIG

³ VHA’s Office of Operational Analytics and Reporting developed a model for understanding a facility’s performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a “star rating” system to designate a facility’s performance in individual measures, domains, and overall quality.
<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

⁴ Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

identified inadequate patient and/or caregiver education related to newly prescribed medications and medication reconciliation to minimize duplicative medications and adverse interactions.

Women's Health

The OIG also noted that the facility performed adequately on women's health indicators, including requirements for a designated women veterans program manager, clinical oversight of the women's health program, data tracking related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. However, the OIG identified a concern with the Women Veterans Health Committee membership lacking consistent representation from the business office, laboratory, mental health, nursing, quality management, radiology, social work, pharmacy, medical and/or surgical subspecialties, and executive leadership.

Summary

In reviewing key healthcare processes, the OIG issued six recommendations for improvement directed to the facility director and chief of staff. The number of recommendations should not be used, however, as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network director and acting facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 53–54, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Alaska VA Healthcare System (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.⁵ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁶ Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

⁵ Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/>. (The website was accessed on January 24, 2019.)

⁶ Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen," March 24, 2015. <http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen>. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).⁷

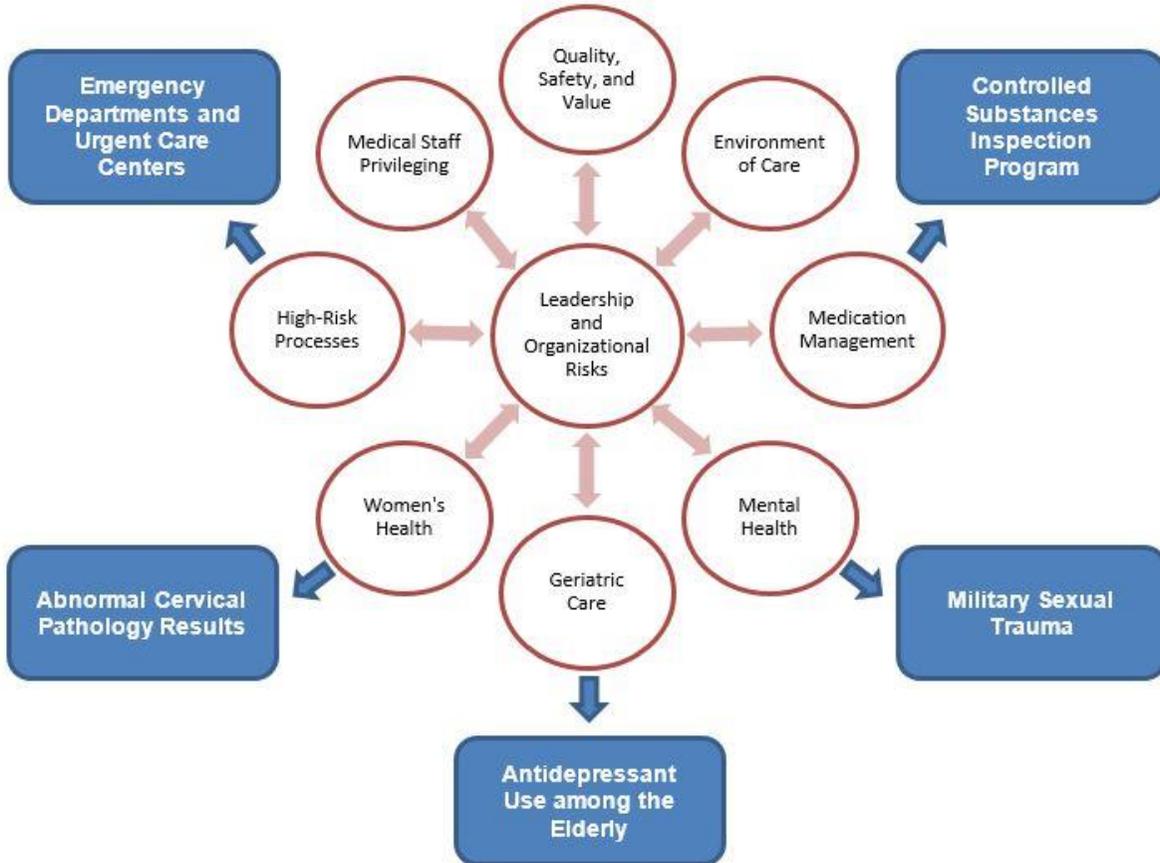


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

⁷ See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;⁸ physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from August 8, 2015, through July 25, 2019, the last day of the unannounced site visit.⁹ While on site, the OIG did not receive any complaints beyond the scope of the CHIP inspection.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The facility director's comments submitted in response to the report recommendations appear within each topic area.

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

⁸ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

⁹ The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.¹⁰ To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services/chief nurse executive (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

¹⁰ L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

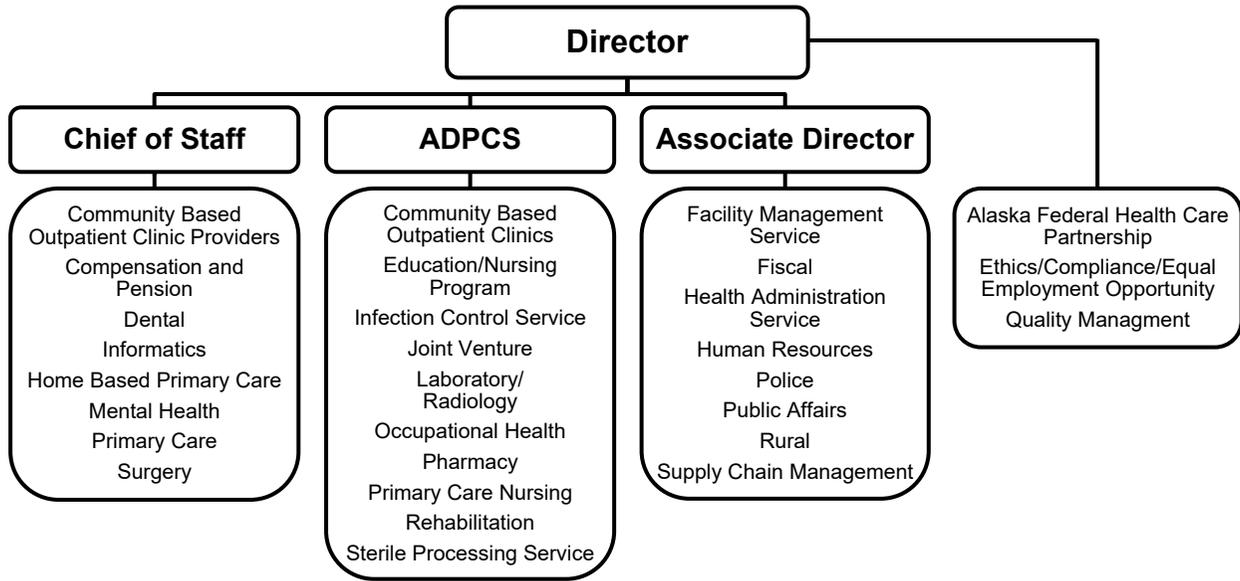


Figure 3. Facility Organizational Chart¹¹
Source: Alaska VA Healthcare System (received July 23, 2019)

At the time of the OIG site visit, the executive team had been working together for 23 months, although the chief of staff had held the position for many years (see Table 1).

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	July 10, 2016
Chief of staff	May 10, 1998
Associate director for Patient Care Services/chief nurse executive	April 16, 2017
Associate director	August 20, 2017

Source: Alaska VA Healthcare System acting human resources officer (received July 23, 2019)

To help assess facility executive leaders’ engagement, the OIG interviewed the director, chief of staff, and ADPCS regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members were generally able to speak knowledgeably about actions taken during the previous 12 months to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders were generally knowledgeable within their scope of responsibilities about selected Strategic

¹¹ At this facility, the director is responsible for the Alaska Federal Health Care Partnership, Ethics/Compliance/Equal Employment Opportunity, and Quality Management.

Analytics for Improvement and Learning (SAIL) metrics. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Leadership Council, with the authority and responsibility for establishing policy, maintaining quality care standards, and performing organizational management and strategic planning. The Executive Leadership Council oversees various working groups, such as the Administrative Executive Board, Clinical Executive Board, and Nurse Executive Board.

These leaders are engaged in monitoring patient safety and care through the Quality Board, for which the quality manager served as the chair and the director served as the co-chair. The Quality Board, which reports to the Executive Leadership Council, is responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes. See Figure 4.

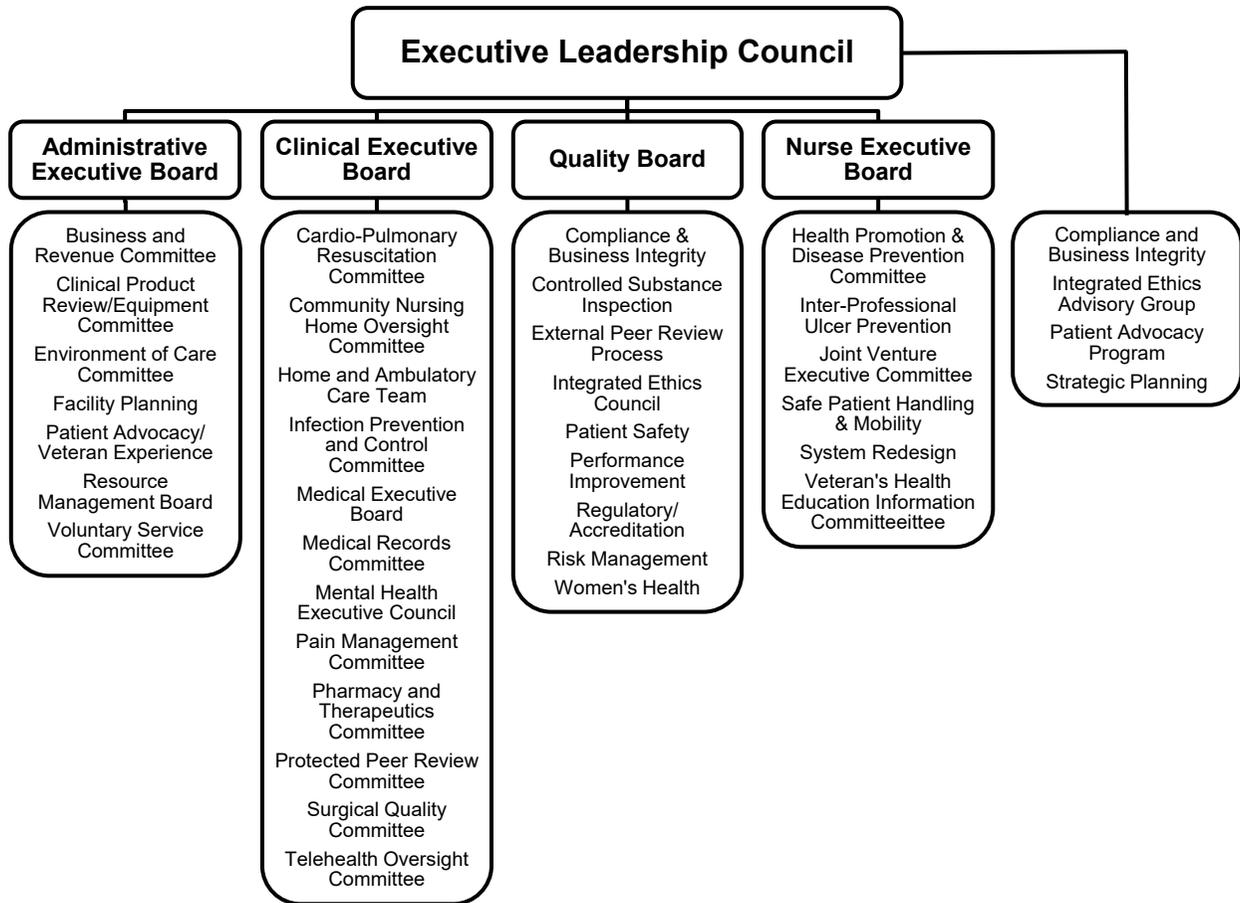


Figure 4. Facility Committee Reporting Structure¹²
Source: Alaska VA Healthcare System (July 23, 2019)

¹² The Executive Leadership Council directly oversees Compliance and Business Integrity, the Integrated Ethics Advisory Group, the Patient Advocacy Program, and Strategic Planning.

Employee Satisfaction

The All Employee Survey is an “annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential.” Since 2001, the instrument has been refined several times in response to VA leaders’ inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.¹³ Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA’s All Employee Survey. The OIG found the facility average for the selected survey leadership questions was higher than the VHA average.¹⁴ The executive team members’ averages were similar to or higher than the VHA average. In all, employees appear generally satisfied with facility leaders.

**Table 2. Survey Results on Employee Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁵	0–100 where HIGHER scores are more favorable	71.7	74.9	95.5	71.4	84.4	90.0

¹³ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

¹⁴ The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

¹⁵ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.8	4.9	3.7	4.6	4.5
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.9	4.9	3.6	4.6	4.5
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.9	4.9	3.9	4.6	4.5

Source: VA All Employee Survey (accessed June 20, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility and executive leadership team averages for the selected survey questions were generally similar to or better than the VHA average. Facility leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns.

**Table 3. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	4.0	5.0	4.1	4.4	4.8

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.8	4.6	3.9	4.3	4.1
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never) – 6 (Every Day)	1.5	1.5	0.8	1.3	1.6	1.4

Source: VA All Employee Survey (accessed June 20, 2019)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through September 30, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.¹⁶

VHA also collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to applicable survey questions that reflect

¹⁶ Ratings are based on responses by patients who received care at this facility.

patients’ attitudes toward facility leaders (see Table 4). For this facility, both outpatient survey results reflected higher care ratings than the VHA average. Patients appeared generally satisfied with the leadership and care provided.

**Table 4. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 2018)**

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.9	n/a ¹⁷
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	84.2	n/a
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.3	82.7
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	76.5	83.5

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 2018)
n/a = not applicable

¹⁷ The facility does not provide inpatient care, therefore the average for the two inpatient survey questions is not applicable (n/a).

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.¹⁸ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).¹⁹ Indicative of effective leadership, the facility has closed all recommendations for improvement.²⁰

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and the College of American Pathologists.²¹

¹⁸ The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

¹⁹ According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides an "internationally accepted external validation that an organization has systems and processes in place to provide safe and quality-oriented health care." TJC "has been accrediting VA medical facilities for over 35 years." Compliance with TJC standards "facilitates risk reduction and performance improvement."

²⁰ A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by the accreditation organization or inspecting agency.

²¹ According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, the Commission on Accreditation of Rehabilitation Facilities "provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies." VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs. According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.) In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the Alaska VA Healthcare System, Anchorage, Alaska, Report No. 15-00618-02, October 29, 2015</i>)	August 2015	22	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Alaska VA Healthcare System, Anchorage, Alaska, Report No. 15-00166-531, September 28, 2015</i>)	August 2015	11	0
OIG (<i>Healthcare Inspection Follow-Up of Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska, Report No. 15-05249-162, March 9, 2017</i>) ²²	n/a	0	0
TJC Ambulatory Health Care Accreditation	August 2016	13	0
TJC Behavioral Health Care Accreditation		4	0
TJC Home Care Accreditation		3	0
TJC Special Unannounced Event	August 2015	1	0

*Source: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on July 25, 2019)
n/a = not applicable.*

²² This report was based on a preceding report that contained nine findings and recommendations. VA Office of Inspector General, *Scheduling, Staffing, and Quality of Care Concerns at the Alaska VA Healthcare System Anchorage, Alaska*, Report No. 14-04077-405, July 7, 2015.

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from August 8, 2015 (the prior comprehensive OIG inspection), through July 25, 2019.²³

**Table 6. Summary of Selected Organizational Risk Factors
(August 8, 2015, through July 25, 2019)**

Factor	Number of Occurrences
Sentinel Events ²⁴	0
Institutional Disclosures ²⁵	6
Large-Scale Disclosures ²⁶	0

*Source: Alaska VA Healthcare System’s chief of Quality Management
(received July 23, 2019)*

Veterans Health Administration Performance Data

The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes “measures on healthcare quality, employee satisfaction, access to care, and efficiency.” It does, however, have noted limitations for identifying all areas of clinical risk. The data are presented as one way to

²³ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Alaska VA Healthcare System is a low complexity (3) facility as described in Appendix B.)

²⁴ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

²⁵ According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical facility leaders together with clinicians and others, as appropriate, inform the patient or [his or her] personal representative that an adverse event has occurred during the patient’s care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.”

²⁶ According to VHA Directive 1004.08, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.”

“understand the similarities and differences between the top and bottom performers” within VHA.²⁷

VA also uses a star rating system where facilities with a “5-star” rating are performing within the top 10 percent of facilities and “1-star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁸ As of June 30, 2018, the facility was rated as “3-star” for overall quality.

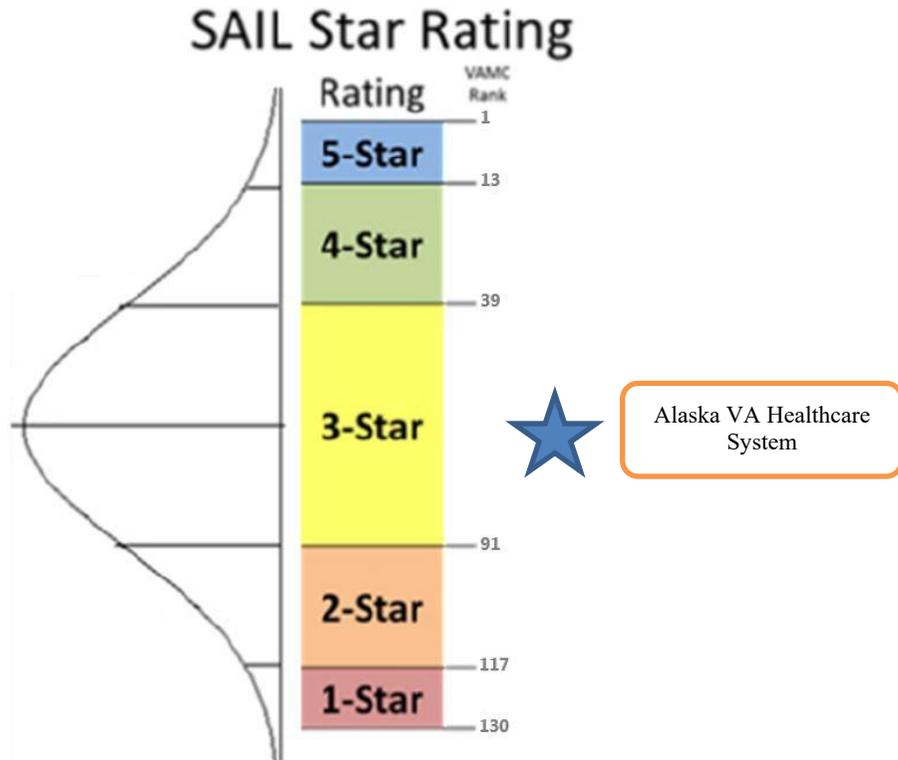


Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)

Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 20, 2019)

Figure 6 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of December 31, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of stress discussed,

²⁷ VHA Support Service Center (VSSC), *The Strategic Analytics for Improvement and Learning (SAIL) Value Model*, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

²⁸ According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

rating (of) specialty care (SC) provider, registered nurse (RN) turnover, best place to work, and rating (of) primary care (PC) provider). Metrics that need improvement are denoted in orange and red (for example, mental health (MH) population (popu) coverage, physician capacity, and MH continuity (of) care).²⁹

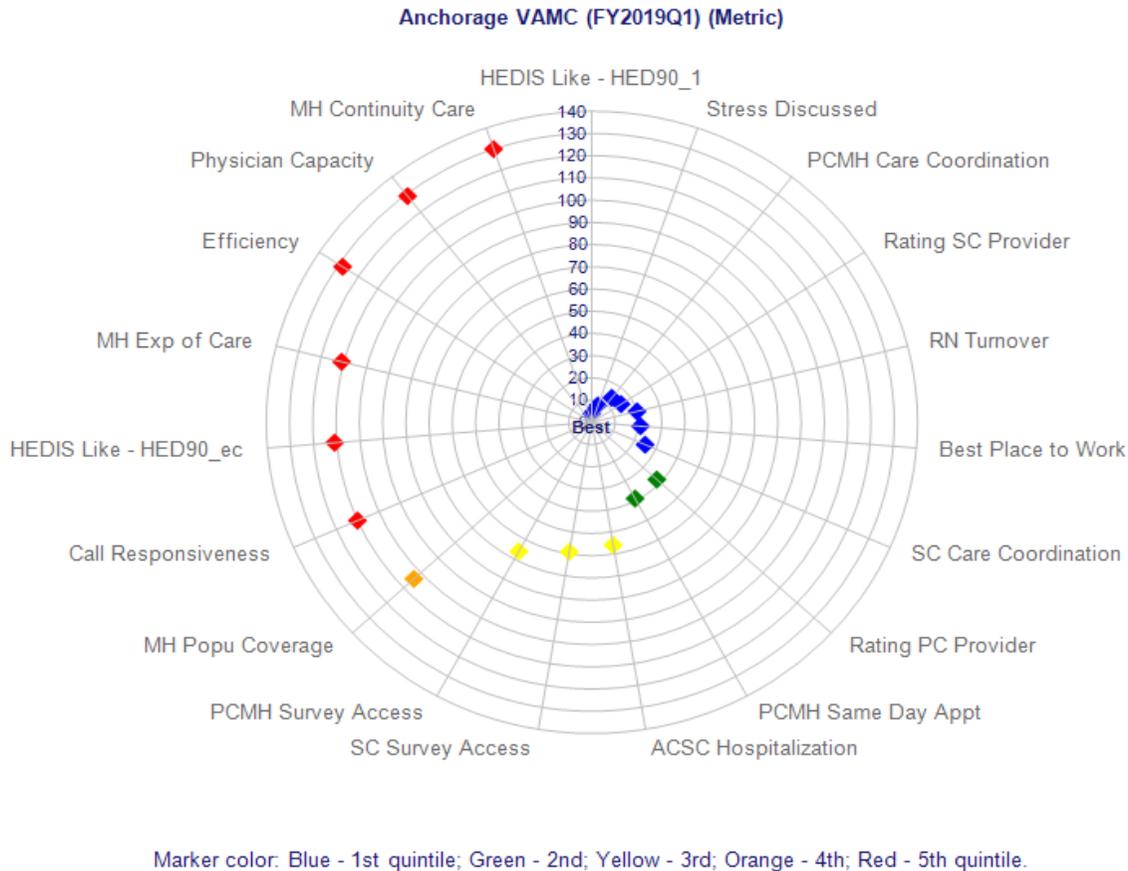


Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2018)

Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). Data definitions are provided in Appendix D.

Leadership and Organizational Risks Conclusion

The facility's executive leadership team appeared relatively stable, with all four positions permanently filled since August 2017. Selected survey scores related to employees' satisfaction with facility executive leaders were generally higher than VHA averages. Further, patient experience survey data revealed that leaders appeared actively engaged with patients. Leaders

²⁹ For information on the acronyms in the SAIL metrics, please see Appendix D.

appeared to support efforts to improve and maintain patient safety and quality care. The OIG's review of the facility's accreditation findings, sentinel events, and patient safety indicator data did not identify any substantial organizational risk factors. The leadership team was knowledgeable within their scope of responsibility about selected SAIL metrics but should continue to take actions to sustain and improve performance of measures contributing to the SAIL "3-star" quality rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁰ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³¹ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³²

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's enterprise framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,³³ utilization management (UM) reviews,³⁴ patient safety incident reporting with related root cause analyses,³⁵ and cardiopulmonary resuscitation (CPR) episode reviews.³⁶

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.³⁷

³⁰ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 but was rescinded on October 24, 2019.)

³¹ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³² VHA Directive 1026.

³³ The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

³⁴ According to VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive expired July 31, 2019.

³⁵ The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

³⁶ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

³⁷ VHA Directive 1190.

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.³⁸

Among VHA's approaches for improving patient safety is the mandated reporting of patient safety incidents to its National Center for Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.³⁹

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.⁴⁰

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:⁴¹

- Protected peer reviews
 - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
 - Completion of final reviews within 120 calendar days
 - Quarterly review of Peer Review Committee's summary analysis by the Medical Executive Committee

³⁸ VHA Directive 1117(2).

³⁹ VHA Handbook 1050.01.

⁴⁰ VHA Directive 1177, VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴¹ For CHIP inspections, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴²
- UM⁴³
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of physician UM advisors' decisions in the National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Annual completion of a minimum of eight root cause analyses⁴⁴
 - Inclusion of required content in root cause analyses (generally)
 - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
 - Provision of feedback about root cause analysis actions to reporting employees
 - Submission of annual patient safety report to facility leaders
- Resuscitation episode review⁴⁵
 - Evidence of a committee responsible for reviewing resuscitation episodes
 - Confirmation of actions taken during resuscitative events being consistent with patients' wishes
 - Evidence of basic or advanced cardiac life support certification for code team responders
 - Evaluation of each resuscitation episode by the CPR Committee or equivalent

⁴² VHA Directive 1190.

⁴³ The facility does not provide inpatient care.

⁴⁴ According to VHA Handbook 1050.01, "the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the [Safety Assessment Code] SAC score assigned to them. At least four analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses]."

⁴⁵ This portion of the review is not applicable since the facility had no resuscitation events.

Quality, Safety, and Value Conclusion

The OIG found general compliance with requirements for protected peer reviews. However, the OIG identified concerns with completing the minimum number of root cause analyses.

VHA requires facilities to complete a minimum of eight root cause analyses during each fiscal year to help identify and mitigate vulnerabilities in their systems of care and to also avoid future occurrences.⁴⁶ The patient safety manager informed the OIG that eight root cause analyses were completed for FY 2018. However, on September 27, 2018, the National Center for Patient Safety (NCPS) notified the chief of Quality Management that one of the eight root cause analyses did not meet the patient safety program's expectation or requirement, resulting in the facility not being credited with having completed the minimum of eight root cause analyses for FY 2018. Not completing an eighth root cause analysis may have prevented the facility from identifying risks and improving system vulnerabilities that could prevent patient harm events. As a result of the NCPS notification at the end of FY 2018, the patient safety manager notified the OIG that an eighth root cause analysis was unable to be completed in time to meet the annual requirement.

Recommendation 1

1. The facility director ensures that the patient safety manager completes a minimum of eight root cause analyses each fiscal year and monitors the patient safety manager's compliance.

Facility concurred.

Target date for completion: July 15, 2020

Facility response: The Patient Safety Manager developed an action tracker for completed and ongoing root cause analyses. During FY19, a total of 11 root cause analyses were completed with results reported monthly to the Quality Board.

⁴⁶ VHA Handbook 1050.01.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all healthcare professionals who are permitted by law and the facility to practice independently”—“without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.” These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁴⁷

Clinical privileges need to be specific, based on the individual’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff and approved by the director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to their expiration.⁴⁸

VHA defines the focused professional practice evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges.” “The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation (OPPE), is essential to confirm the quality of care delivered.”⁴⁹

According to TJC, the “FPPE for Cause” should be used when a question arises regarding a privileged provider’s ability to deliver safe, high-quality patient care. The “FPPE for Cause” is limited to a particular time frame and customized to the specific provider and related clinical concerns.⁵⁰ Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.⁵¹

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

⁴⁷ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

⁴⁸ VHA Handbook 1100.19.

⁴⁹ VHA Handbook 1100.19.

⁵⁰ Office of Safety and Risk Awareness, Office of Quality and Performance, *Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*, July 2016 (Revision 2).

⁵¹ VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- No solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁵²
- Seven LIPs hired within 18 months before the site visit
- Twelve LIPs re-privileged within 12 months before the visit
- One provider who underwent a FPPE for cause within 12 months prior to the visit

The OIG evaluated the following performance indicators:

- Privileging
 - Privileges requested by the provider
 - Facility-specific
 - Service-specific
 - Provider-specific⁵³
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and time frames clearly documented
 - Evaluation by another provider with similar training and privileges
 - Executive Committee of the Medical Staff’s consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁵² The 18-month period was from January 22, 2018, through July 22, 2019. The 12-month review period covered July 22, 2018, through July 22, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers “few practitioners” as being fewer than three providers in the facility that are privileged in a particular specialty.

⁵³ According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- Service chief's determination to recommend continuation of current privileges was based in part on the results of OPPE activities
- Evaluation by another provider with similar training and privileges
- Executive Committee of the Medical Staff's decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
 - Clearly defined expectations/outcomes
 - Time-limited
 - Provider's ability to practice independently not limited for more than 30 days
 - Shared with the provider in advance
- Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

Generally, the facility met requirements as reflected by the performance indicators above. The OIG made no recommendations.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.⁵⁴

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.⁵⁵

VHA requires its facilities to have the “capacity for [providing] mental health services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.⁵⁶

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.⁵⁷ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,⁵⁸

⁵⁴ VHA Directive 1608, *Comprehensive Environment of Care (CEOC Program)*, February 1, 2016.

⁵⁵ Applicable requirements for high-risk areas and emergency management include those detailed in or by various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

⁵⁶ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

⁵⁷ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

⁵⁸ VHA Directive 1028, *Electrical Power Distribution Systems*, July 25, 2014. (This VHA directive was scheduled for recertification on or before the last working date of July 2019 and has not been recertified.)

Occupational Safety and Health Administration,⁵⁹ and National Fire Protection Association standards.⁶⁰ The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁶¹

In all, the OIG team inspected eight areas—the specialty, primary care, dental, audiology, and behavioral health clinics; and the laboratory, physical therapy and radiology departments. The team also inspected the Juneau VA Clinic and the emergency management program. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Community based outpatient clinic
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Locked inpatient mental health unit⁶²
 - Mental health environment of care rounds
 - Nursing station security
 - Public area and general unit safety

⁵⁹ The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html>. (This website was accessed on June 28, 2018.)

⁶⁰ The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA>. (This website was accessed on June 28, 2018.)

⁶¹ TJC. Environment of Care standard EC.02.05.07.

⁶² The facility did not have an inpatient mental health unit.

- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency management
 - Hazard vulnerability analysis (HVA)
 - Emergency operations plan (EOP)
 - Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility achieved the performance indicators above. The OIG made no recommendations.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.⁶³ Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.⁶⁴

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.⁶⁵

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;⁶⁶ and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend reports to the director
 - Quality Management Committee’s review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁶⁷
- Requirements for controlled substances inspectors

⁶³ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁶⁴ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

⁶⁵ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁶⁶ The two quarters were from January 1, 2019, through June 30, 2019.

⁶⁷ Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No conflicts of interest
- Appointed in writing by the director for a term not to exceed three years
- Hiatus of one year between any reappointment
- Completion of required annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁶⁸
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of twice a week (three days apart) inventories of the main vault⁶⁹
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁷⁰

⁶⁸ According to VHA Directive 1108.02(1), the Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁶⁹ VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (This handbook was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.)

⁷⁰ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

Medication Management Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including controlled substances coordinator reports, pharmacy operations, requirements for controlled substances inspectors, and non-pharmacy and pharmacy area inspections. The OIG identified noncompliance with the review of override reports that warranted a recommendation for improvement.

TJC requires that when automatic dispensing cabinets (ADCs) are used, “the hospital has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews.”⁷¹ The facility staff informed the OIG that ADC override reports were not reviewed. Failure to perform reviews of ADC overrides can potentially lead to a loss and diversion of controlled substances medications and risk patient safety. The controlled substance coordinator and chief of Pharmacy perceived that they were meeting the requirement per facility policy, which states overrides cannot be used for controlled substances and only performed in urgent situations.⁷²

Recommendation 2

2. The facility director ensures that a formal process is established to review override reports and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The override function on the automated dispensing machine has been disabled. The pharmacy chief will extract monthly override reports to verify the disabled status and detect any override activity. The controlled substance inspection program manager will include the override report within the controlled inspection report. Monthly reports will be provided to the Quality Board until 100% compliance is demonstrated for a minimum of 6 consecutive months.

⁷¹ TJC. Medication Management standard MM.08.01.01, EP16.

⁷² Alaska VA Healthcare System, Policy 118-42.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term “military sexual trauma” (MST) to refer to a “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”⁷³ MST is an experience, not a diagnosis or a mental health condition. Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.⁷⁴

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.⁷⁵ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁷⁶

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.⁷⁷ Those who screen positive must have access to appropriate MST-related care.⁷⁸ VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.⁷⁹

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.⁸⁰ All mental health and primary care providers must complete MST mandatory

⁷³ VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁷⁴ Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁷⁵ VHA Directive 1115.

⁷⁶ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015). (This VHA handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

⁷⁷ VHA Directive 1115 states that “MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.”

⁷⁸ VHA Directive 1115.

⁷⁹ VHA Handbook 1160.01.

⁸⁰ VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.⁸¹

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 49 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
 - Establishes and monitors MST-related staff training
 - Establishes and monitors informational outreach
 - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
 - Referral for MST-related care to patients with positive MST screens
 - Initial evaluation within 24 hours of referral for mental health services
 - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. There was concern noted with providers completing MST mandatory training within the required time frame that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after entering their position.⁸² The OIG found that 3 of 16 providers hired after July 1, 2012, did not complete training within 90 days. This could potentially result in clinicians

⁸¹ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017. Acting Deputy Under Secretary for Health for Operations and Management, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

⁸² VHA Directive 1115.01; Acting Deputy Under Secretary for Health for Operations and Management.

providing counseling, care, and service without the required MST training. The MST coordinator acknowledged a lack of oversight but also reported attending new employee orientation to ensure staff know to complete the required MST training within expected time frame.

Recommendation 3

3. The facility director makes certain that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: July 1, 2020

Facility response: The current overall military sexual trauma training compliance is 97.73% amongst relevant providers. Any providers who are overdue will complete the mandatory training by January 30, 2020. During new employee training, all relevant providers will be assigned and complete the mandatory training prior to being released into the service. The military sexual trauma coordinator will receive a monthly report from the chief of education to monitor compliance. The military sexual trauma coordinator will report training compliance to the Quality Board monthly until 100% compliance is demonstrated for a minimum of 6 consecutive months.

Numerator = # of all primary care and mental health providers who have completed MST training within 90 days of assuming position.

Denominator = # of all primary care and mental health providers required to complete MST training.

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."⁸³ The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.⁸⁴

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."⁸⁵

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.⁸⁶ The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."⁸⁷ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.⁸⁸ Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.⁸⁹ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

⁸³ Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

⁸⁴ *VA/DoD Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf>. (The website was accessed November 20, 2018.)

⁸⁵ Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

⁸⁶ American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sgot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

⁸⁷ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

⁸⁸ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

⁸⁹ TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.⁹⁰

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 18 selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.⁹¹ The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

The OIG found compliance with providers justifying the reason for medication initiation and validating general patient and/or caregiver understanding after educating them about newly prescribed medications. However, the OIG discovered inadequate patient and/or caregiver education specific to newly prescribed antidepressant drugs and that providers did not reconcile patients' medications. These findings warranted recommendations for improvement.

TJC requires that clinicians educate patients and families about safe and effective use of medications and that the patient's medical record contains information that reflects the patient's care, treatment, and services.⁹² The OIG found that clinicians provided education to 56 percent of the patients, based on electronic health records reviewed.⁹³ Providing medication education is important because patients need to be able to manage their own health at home.⁹⁴ The associate chief of clinical pharmacy stated the template used by providers did not comprehensively capture the medication education given to patients.

⁹⁰ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

⁹¹ The seven selected antidepressant medications are amitriptyline, clomipramine, desipramine, doxepin (>6mg/day), imipramine, nortriptyline, and paroxetine.

⁹² TJC. Provision of Care standard PC.02.03.01, EP10.

⁹³ Confidence intervals are not included because the data represents every patient in the study population.

⁹⁴ TJC. Provision of Care standard PC.02.03.01.

Recommendation 4

4. The chief of staff verifies that clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: July 1, 2020

Facility response: The chief of staff will reinforce clinician accountability for providing and documenting patient and/or caregiver education by monitoring results of a monthly random audit of the electronic health records of 10 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications during their most recent visit. Monitoring data will be reported and discussed at the Quality Board monthly until 90% or greater compliance is demonstrated for minimum of 6 consecutive months.

According to TJC, for medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.⁹⁵ TJC also requires patients' medical record contains information that reflects the patient's care, treatment, and services.⁹⁶ Additionally, VHA requires that clinicians review and reconcile medications relevant to the episode of care.⁹⁷ The OIG found that clinicians performed medication reconciliation for 83 percent of the patients, based on electronic health records reviewed.⁹⁸ Failure to reconcile medications increases the risk for duplications, omissions, and interactions in the patient's actual drug regimen.⁹⁹ The associate chief of clinical pharmacy reported a lack of attention to detail, specifically that medication reconciliations were missed during nonstandard (not scheduled) appointments.

Recommendation 5

5. The chief of staff ensures clinicians review and reconcile medications and monitors clinicians' compliance.

⁹⁵ TJC. National Patient Safety Goal standard NPSG.03.06.01.

⁹⁶ TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

⁹⁷ VHA Directive 1164.

⁹⁸ Confidence intervals are not included because the data represents every patient in the study population.

⁹⁹ TJC. Rationale for National Patient Safety Goal standard NPSG.03.06.01.

Facility concurred.

Target date for completion: July 1, 2020

Facility response: A standardized medication reconciliation template was developed to be utilized by all prescribing providers within the primary care service and behavioral health service for documentation of patient medication reconciliation. Training sessions were provided to prescribing providers on the use of the template.

Quality Management will conduct 10 random chart audits per month to review clinician's medication reconciliation compliance. Monitoring data will be report to the Quality Board monthly until 90% compliance is demonstrated for a minimum of 6 consecutive months.

Numerator = # of charts reviewed with documented clinician medication reconciliation.

Denominator = # of charts reviewed with medications.

Women’s Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.¹⁰⁰ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹⁰¹ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.¹⁰² Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹⁰³

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.¹⁰⁴

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee (WVHC) comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.¹⁰⁵

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the

¹⁰⁰ Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

¹⁰¹ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹⁰² Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

¹⁰³ Centers for Disease Control and Prevention. *Basic Information About Cervical Cancer*, February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹⁰⁴ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

¹⁰⁵ VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹⁰⁶

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 17 women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veteran program manager
 - Appointment of a women’s health medical director or clinical champion
- Facility Women Veterans Health Committee
 - Core membership
 - Quarterly meetings
 - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
 - Notification of patients due for screening
 - Completed screenings
 - Results reporting
 - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women’s Health Conclusion

Generally, the OIG found compliance with many of the performance indicators, including requirements for a designated women veterans program manager and clinical champion, clinical oversight of the women’s health program, tracking of data related to cervical cancer screenings, communication of results to patients within the required time frame, and follow-up care when indicated. The OIG noted a concern with the Women Veterans Health Committee membership that warranted a recommendation for improvement.

Specifically, VHA requires that the core membership of the Women Veterans Health Committee includes a women veterans program manager; a women’s health medical director;

¹⁰⁶ VHA Directive 1330.01(2).

“representatives from primary care, mental health, medical and/or surgical subspecialties, gynecology, pharmacy, social work and care management, nursing, ED [emergency department], radiology, laboratory, quality management, business office/Non-VA Medical Care; and a member from executive leadership.”¹⁰⁷ The OIG reviewed Women Veterans Health Committee (known as the Women’s Health Committee) minutes from January 2019 through June 2019 and found the committee lacked consistent representation from the business office, laboratory, mental health, nursing, quality management, radiology, social work, pharmacy, medical and/or surgical subspecialties, and executive leadership. This resulted in a lack of expertise and oversight in the review and analysis of data as the committee planned and carried out improvements for quality and equitable care for women veterans. The women veterans program manager acknowledged less-than-optimal attendance and reported sending email meeting reminders to the required core members to increase participation. However, the women veterans program manager did not discuss poor core member attendance with executive leaders due to lack of follow-through.

Recommendation 6

6. The facility director confirms that the Women’s Health Committee is comprised of the required core members and monitors committee’s compliance.

Facility concurred.

Target date for completion: July 1, 2020

Facility response: The Women Veterans Program manager reviewed and confirmed the required core members are within the Women’s Health Committee charter. The women veteran’s health coordinator advised required representatives on attendance requirements per VHA Directive 1330.03. The Women Veterans Program Manager will audit the Women’s Health Committee required core members attendance. Service chiefs will address with required core members if attendance drops below 90%. Attendance data will be reported monthly to the Quality Board monthly until 90% compliance is demonstrated for 6 consecutive months.

Numerator = # of required Women’s Health Committee members attendance

Denominator = # of required Women’s Health Committee members required to attend

¹⁰⁷ VHA Directive 1330.01(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data 	Six OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer reviews • Patient safety • Resuscitation episode review 	<ul style="list-style-type: none"> • The patient safety manager ensures completion of the required minimum of eight root cause analyses each fiscal year. 	<ul style="list-style-type: none"> • None
Medical Staff Privileging	<ul style="list-style-type: none"> • Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Emergency management <ul style="list-style-type: none"> ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<ul style="list-style-type: none"> • Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • A formal process is established to review override reports.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<ul style="list-style-type: none"> • Designated facility MST coordinator • Evidence of tracking MST-related data • Provision of clinical care • Completion of MST mandatory training requirement for mental health and primary care providers 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Primary care and mental health providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	<ul style="list-style-type: none"> • Justification for medication initiation • Evidence of patient and/or caregiver education specific to the medication prescribed • Clinician evaluation of patient and/or caregiver understanding of the education provided • Medication reconciliation 	<ul style="list-style-type: none"> • Clinicians provide and document patient and/or caregiver education about the safe and effective use of newly prescribed medications. • Clinicians review and reconcile medications. 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up</p>	<ul style="list-style-type: none"> • Appointment of a women veterans program manager • Appointment of a women's health medical director or clinical champion • Facility Women Veterans Health Committee • Collection and tracking of cervical cancer screening data • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • The Women's Health Committee is comprised of the required core members.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low complexity (3) facility reporting to VISN 20.¹⁰⁸

**Table B.1. Facility Profile for Alaska VA Healthcare System (463)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹⁰⁹	Facility Data FY 2017 ¹¹⁰	Facility Data FY 2018 ¹¹¹
Total medical care budget in dollars	\$186,500,814	\$200,804,087	\$257,166,149
Number of:			
• Unique patients	21,612	21,536	22,150
• Outpatient visits	173,052	164,153	183,496
• Unique employees ¹¹²	467	480	515
Type and number of operating beds:			
• Domiciliary	50	50	50
• Residential rehabilitation	24	24	24
Average Daily Census:			
• Domiciliary	41	45	43
• Residential rehabilitation	5	6	12

Source: VHA Support Service Center, and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

¹⁰⁸ The VHA medical centers are classified according to a facility complexity model; a designation of “3” indicates a facility with “low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs.”

¹⁰⁹ October 1, 2015, through September 30, 2016.

¹¹⁰ October 1, 2016, through September 30, 2017.

¹¹¹ October 1, 2017, through September 30, 2018.

¹¹² Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles¹¹³

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)¹¹⁴

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹¹⁵ Provided	Diagnostic Services ¹¹⁶ Provided	Ancillary Services ¹¹⁷ Provided
Fort Wainwright, AK	463GA	7,572	2,951	Gastroenterology Poly-Trauma Eye Podiatry	n/a	Weight management
Kenai, AK	463GB	6,187	2,420	Dermatology Poly-Trauma Eye Podiatry	n/a	Pharmacy Weight management

¹¹³ Includes all outpatient clinics in the community that were in operation as of February 8, 2019.

¹¹⁴ The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015, and has not been updated.) An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

¹¹⁵ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹¹⁶ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹¹⁷ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

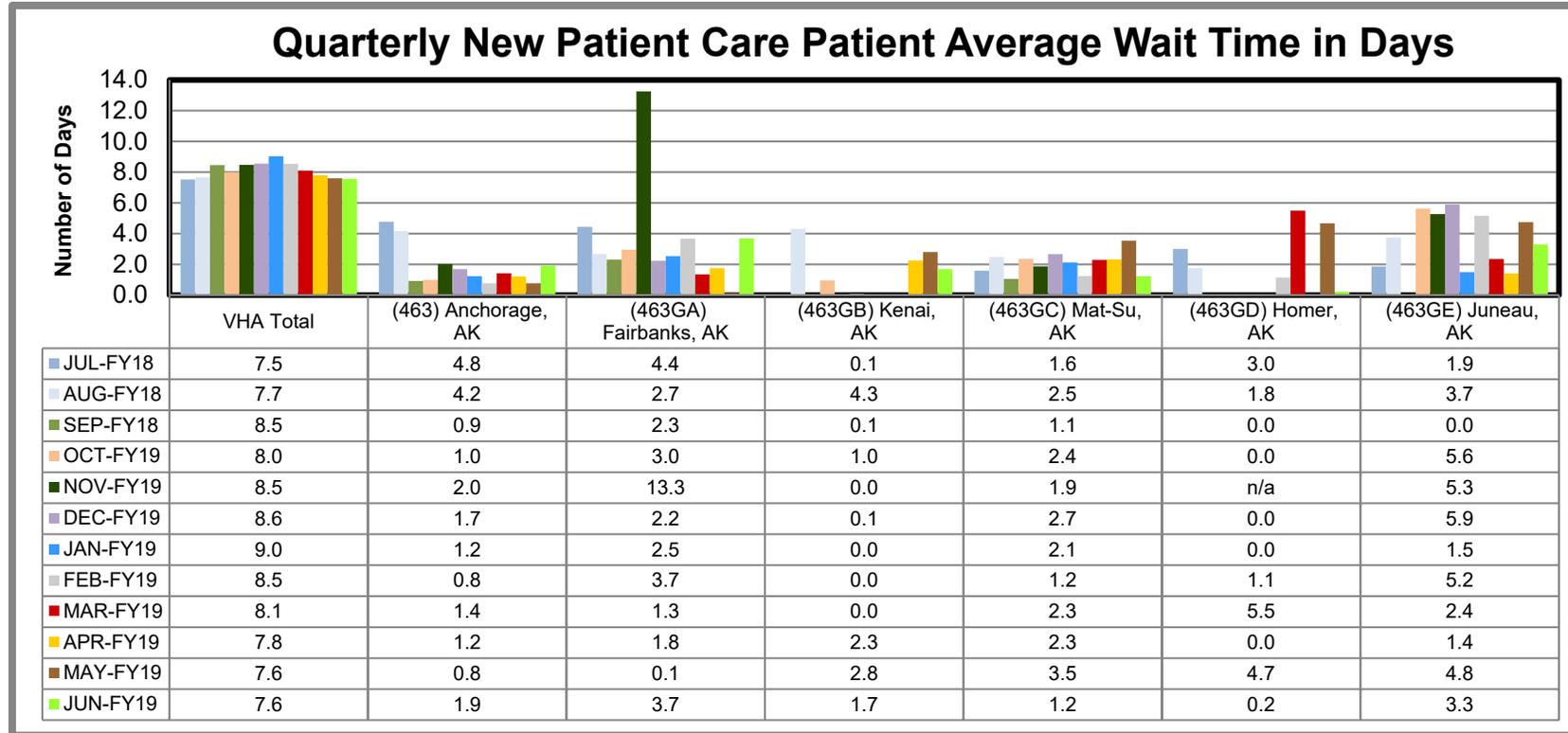
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹¹⁵ Provided	Diagnostic Services ¹¹⁶ Provided	Ancillary Services ¹¹⁷ Provided
Wasilla, AK	463GC	6,277	2,098	Dermatology Eye Podiatry	n/a	Pharmacy Weight management
Homer, AK	463GD	883	394	Podiatry	n/a	Pharmacy'
Juneau, AK	463GE	3,116	739	Cardiology Dermatology Gastroenterology Eye	n/a	Pharmacy Social work Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: The OIG did not assess VA's data for accuracy or completeness.

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹¹⁸



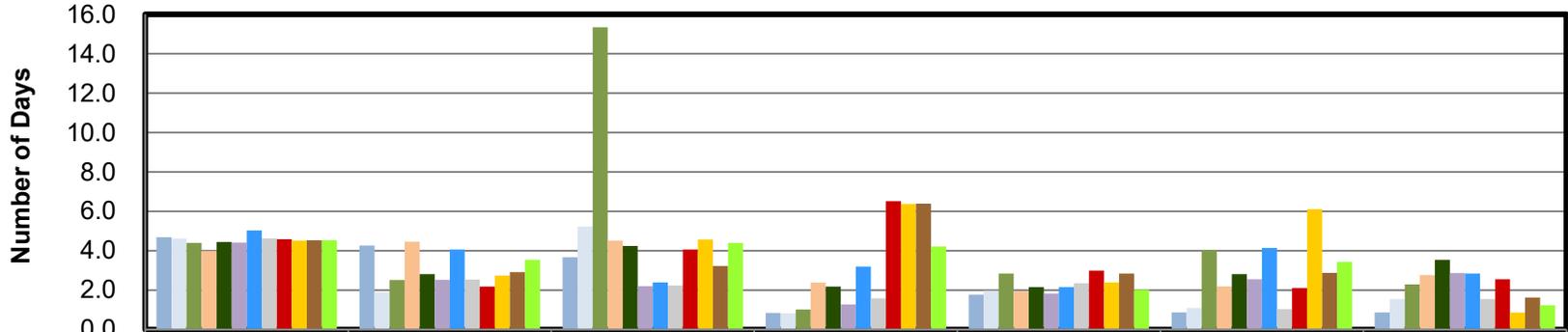
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness

Data Definition: "The average number of calendar days between a New Patient's Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date." Note that prior to FY15, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."

¹¹⁸ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(463) Anchorage, AK	(463GA) Fairbanks, AK	(463GB) Kenai, AK	(463GC) Mat-Su, AK	(463GD) Homer, AK	(463GE) Juneau, AK
JUL-FY18	4.7	4.3	3.7	0.8	1.8	0.9	0.9
AUG-FY18	4.6	1.9	5.2	0.8	2.0	1.1	1.5
SEP-FY18	4.4	2.5	15.3	1.0	2.8	4.1	2.3
OCT-FY19	4.0	4.5	4.5	2.4	1.9	2.2	2.8
NOV-FY19	4.4	2.8	4.2	2.2	2.2	2.8	3.5
DEC-FY19	4.4	2.5	2.2	1.3	1.8	2.6	2.9
JAN-FY19	5.0	4.1	2.4	3.2	2.2	4.1	2.8
FEB-FY19	4.6	2.5	2.2	1.6	2.4	1.0	1.5
MAR-FY19	4.6	2.2	4.1	6.5	3.0	2.1	2.6
APR-FY19	4.5	2.7	4.6	6.4	2.4	6.1	0.9
MAY-FY19	4.5	2.9	3.2	6.4	2.8	2.9	1.6
JUN-FY19	4.5	3.5	4.4	4.2	2.0	3.4	1.2

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness.

Data Definition: “The average number of calendar days between an Established Patient’s Primary Care completed appointment (clinic stops 322, 323, and 350, excluding [Compensation and Pension] appointments) and the earliest of [three] possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.”

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹¹⁹

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

¹¹⁹ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care associated infections	A lower value is better than a higher value
HEDIS like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS like – HED90_1	HEDIS-EPRP based PRV TOB BHS	A higher value is better than a lower value
HEDIS like – HED90_ec	HEDIS-eOM based DM IHD	A higher value is better than a lower value
MH wait time	Mental health care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH continuity care	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	ORYX	A higher value is better than a lower value
PC routine care appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC urgent care appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH care coordination	PCMH care coordination	A higher value is better than a lower value
PCMH same day appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH survey access	Timely appointment, care and information (PCMH)	A higher value is better than a lower value
Physician capacity	Physician capacity	A lower value is better than a higher value
PC wait time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value

Measure	Definition	Desired Direction
Rating hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower value
SC routine care appt	Timeliness in getting a SC routine care appointment (specialty care)	A higher value is better than a lower value
SC survey access	Timely appointment, care and information (specialty care)	A higher value is better than a lower value
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty care wait time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress discussed	Stress discussed (PCMH Q40)	A higher value is better than a lower value
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: December 26, 2019

From: Director, Northwest Network (10N20)

Subj: Comprehensive Healthcare Inspection of the Alaska VA Healthcare System,
Anchorage, AK

To: Director, Chicago Office of Healthcare Inspections (54CH02)

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

1. Thank you for the opportunity to review the VA Office of Inspector General's Comprehensive Healthcare Inspection Program report of the VA Alaska Healthcare System. I concur with the assessment and finding and appreciate the review team's thoroughness and dedication to quality improvement across the VA.

2. I concur with the findings, recommendations and submitted action plans. Attached please find the facility concurrence and response to the findings from the review.

(Original signed by:)

Dr. Chris Curry, Acting Chief Medical Officer
for Michael J. Murphy
Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: December 26, 2019

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

Subj: Comprehensive Healthcare Inspection of the Alaska VA Healthcare System
Anchorage, AK

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to review the VA Office of Inspector General's Comprehensive Healthcare Inspection Program report of the VA Alaska Healthcare System. I concur with the assessment and finding and appreciate the review team's thoroughness and dedication to quality improvement across the VA.
2. A corrective action plan remedying identified deficiencies is provided. VA Alaska will continue to monitor performance to ensure all recommendations are addressed and action plans successfully implemented.

(Original signed by:)

Timothy D. Ballard, MD, MS
Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

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