Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00618-02

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

October 29, 2015

Washington, DC 20420

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

Glossary

CAP	Combined Assessment Program
CS	controlled substances
EHR	electronic health record
EOC	environment of care
facility	Alaska VA Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
RRTP	residential rehabilitation treatment program
SCI	spinal cord injury
VHA	Veterans Health Administration

Table of Contents

	Page
Executive Summary	i
Objectives and Scope	1
Objectives	1
Scope	1
Reported Accomplishment	2
Results and Recommendations	3
QM	3
EOC	7
Medication Management – CS Inspections	10
Continuity of Care	12
Mammography Services	13
Suicide Prevention Program	15
Management of Workplace Violence	17
MH RRTP	19
Review Activity with Previous CAP Recommendations	21
Follow-Up on QM	21
Appendixes	
A. Facility Profile	22
B. Strategic Analytics for Improvement and Learning	23
C. Veterans Integrated Service Network Director Comments	26
D. Interim Facility Director Comments	27
E. Office of Inspector General Contact and Staff Acknowledgments	35
F. Report Distribution	36
G. Endnotes	37

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 3, 2015.

Review Results: The review covered eight activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following activity:

- Continuity of Care

The facility's reported accomplishment was development of multiple partnerships with the community to ensure timely access to care for veterans in a highly rural state with limited health care resources.

Recommendations: We made recommendations in the following seven activities and follow-up review area:

Quality Management: Ensure the Facility Director and other key members required by local policy attend Quality Committee meetings or have a delegate represent them. Require that licensed independent practitioners' folders do not contain non-allowed information. Establish a committee to provide oversight of the safe patient handling program. Analyze electronic health record quality data at least quarterly. Include required elements in the quality control policy for scanning. Complete an audit to ensure all licensed independent practitioners' privileges are current.

Environment of Care: Ensure the health care occupancy building has at least one fire drill during administrative hours per quarter. Store clean and dirty items separately. Revise the tuberculosis prevention plan policy to reflect current status of negative air exchange rooms in the primary care clinic, and ensure employees are aware of procedures to care for infectious patients in lieu of negative air exchange rooms.

Medication Management – Controlled Substances Inspections: Correct all deficiencies identified during annual physical security surveys. Consistently complete a physical count of all primary care clinics during the 1st month of each quarter and a physical count of 10 line items for all primary care clinics during the 2nd and 3rd months of each quarter. Consistently complete pharmacy inspections on the same day initiated.

Mammography Services: Link mammogram results to the radiology order in the electronic health record. Send written lay mammogram results to patients within 30 days of the procedure, and reflect this in the electronic health record. Communicate incomplete or "probably benign" results to patients within 14 days from availability of the results, and document this in the electronic health record.

Suicide Prevention Program: Ensure new employees receive suicide prevention training. Require that all patients assessed to be at high risk for suicide have documented safety plans that specifically address suicidality and that patients and/or their families receive a copy of the safety plan.

Management of Workplace Violence: Implement an Employee Threat Assessment Team and a centralized disruptive behavior reporting and tracking system.

Mental Health Residential Rehabilitation Treatment Program: Ensure monthly Domiciliary Care for Homeless Veterans Program self-inspection documentation includes safety, security, and privacy.

Follow-Up on Quality Management: Continue the recently implemented peer review corrective action tracking process, and ensure actions are completed and reported to the Peer Review Committee. Consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners at the time or before they begin providing patient care.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 26–34, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

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

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

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities and follow-up review area from the previous CAP review:

- QM
- EOC
- Medication Management – CS Inspections
- Continuity of Care
- Mammography Services
- Suicide Prevention Program
- Management of Workplace Violence
- MH RRTP
- Follow-Up on QM

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

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through August 19, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Alaska VA Healthcare System, Anchorage, Alaska*, Report No. 13-00890-220, June 20, 2013). We made repeat recommendations in QM.

During this review, we presented crime awareness briefings for 72 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 373 responses. We shared summarized results with the Facility Director.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishment

Community Partnerships and Outreach

The facility has developed multiple partnerships with the community to ensure timely access to care for veterans in a highly rural state with limited health care resources. The facility expanded its Native Sharing and Reimbursement Agreements with Alaska Tribal Health Programs to provide primary and specialty care for both Native and non-Native veterans and eliminated resource redundancies in surgical operations through the consolidation of ophthalmology and surgical services, which strengthened Joint Venture/Department of Defense partnerships already in place. Additionally, the facility leveraged private sector network support for primary, inpatient, and specialty care to process more than 4,000 referrals per month through Patient-Centered Community Care and Non-VA Care Coordination initiatives. When the Veterans Choice Program was recently implemented, the facility trained and deployed four "Choice Champions," hired a benefits counselor, renovated space to support a Choice customer service center, and conducted group and individual vendor education offerings. The facility also provided veteran community listening sessions in several communities in Alaska. In response to unintended consequences related to facility funding and challenges with the application of the Veterans Choice Program in Alaska, VHA leadership allowed the facility to reprogram funds to continue use of Department of Defense and Tribal Health partners.

Workload through July 2015 indicated that the facility has coordinated more than 13,000 referrals through the Veterans Choice Program, Department of Defense partnerships, and Native Sharing Agreements.

Results and Recommendations

QM

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

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
X	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.	Twelve months of Quality Committee meeting minutes reviewed: • The Facility Director did not attend 10 meetings and had not delegated chairmanship to another member of senior leadership. • Seven of 13 key members required by local policy did not attend eight meetings and did not have a delegate represent them.	**1.** We recommended that the Facility Director and other key members required by local policy attend Quality Committee meetings or have a delegate represent them.
	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• All 10 of the licensed independent practitioners' folders reviewed contained non-allowed information.	**2.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
NA	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
NA	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.		

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
NA	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The facility did not have a committee that provided oversight of the safe patient handling program.	**3.** We recommended that the facility establish a committee to provide oversight of the safe patient handling program.
X	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.	Four quarters of Medical Record Review Business Meeting minutes reviewed: • Although the committee conducted EHR reviews, it did not analyze EHR quality data. This was a repeat finding from the previous CAP review.	**4.** We recommended that the facility analyze electronic health record quality data at least quarterly.
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy did not include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents.	**5.** We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
X	The facility met any additional elements required by VHA or local policy.	VHA policy reviewed, which requires all licensed independent health care professionals to have current clinical privileges. • One of the 10 licensed independent practitioners whose folders we reviewed had been involved in patient care with expired privileges for a period of 6 months.	**6.** We recommended that the Chief of Staff complete an audit of all licensed independent practitioners' privileges to ensure they are current and that facility managers monitor compliance.

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the surgery, primary care, physical therapy, and dental clinics. Additionally, we reviewed relevant documents, including 10 employee training records, and conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Two quarters of fire drill documentation for the health care occupancy building reviewed: • The building did not have at least one fire drill during administrative hours per quarter.	**7.** We recommended that facility managers ensure the health care occupancy building has at least one fire drill during administrative hours per quarter and monitor compliance.
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• Three of four patient care areas had clean and dirty items stored together.	**8.** We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Facility tuberculosis prevention plan policy reviewed, which identifies two negative air exchange rooms in the primary care clinic that require air exchange monitoring. • Although the facility no longer identifies these rooms as negative air exchange rooms, facility policy does not reflect this change.	**9.** We recommended that the facility revise the tuberculosis prevention plan policy to reflect current status of negative air exchange rooms in the primary care clinic and ensure employees are aware of procedures to care for infectious patients in lieu of negative air exchange rooms.
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		

NM	Areas Reviewed for SCI Center (continued)	Findings	Recommendations
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management – CS Inspection Program

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

We reviewed relevant documents and conversed with key employees. We also reviewed the training files of the CS Coordinator and 10 CS inspectors and inspection documentation from two CS areas and the pharmacy. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy was consistent with VHA requirements.		
X	VA police conducted annual physical security surveys of the pharmacy/pharmacies, and the facility corrected any identified deficiencies.	Annual physical security surveys for past 2 years reviewed: • The facility had not corrected four identified deficiencies, and managers were just in the process of correcting the deficiencies while we were onsite.	**10.** We recommended that facility managers ensure correction of all deficiencies identified during annual physical security surveys.
	The facility had documented instructions for inspecting automated dispensing machines that included all required elements, and CS inspectors followed the instructions.		
	The CS Coordinator provided monthly CS inspection findings summaries and quarterly trend reports to the Facility Director.		
	The CS Coordinator position description or functional statement included CS oversight duties, and the CS Coordinator completed required certification and was free from conflicts of interest.		
	The Facility Director appointed CS inspectors in writing, and inspectors were limited to 3-year terms, completed required certification and training, and were free from conflicts of interest.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	CS inspectors inspected non-pharmacy areas with CS in accordance with VHA requirements, and inspections included all required elements.	Documentation of two CS areas inspected during the past 6 months reviewed: • CS inspectors did not consistently complete a physical count of all primary care clinics during the 1st month of each quarter. • CS inspectors did not consistently complete a physical count of 10 line items for all primary care clinics during the 2nd and 3rd months of each quarter.	**11.** We recommended that controlled substances inspectors consistently complete a physical count of all primary care clinics during the 1st month of each quarter and a physical count of 10 line items for all primary care clinics during the 2nd and 3rd months of each quarter and that the Controlled Substances Coordinator monitors compliance.
X	CS inspectors conducted pharmacy CS inspections in accordance with VHA requirements, and inspections included all required elements.	Documentation of pharmacy CS inspections conducted during the past 6 months reviewed: • CS inspectors did not consistently complete pharmacy inspections on the same day initiated.	**12.** We recommended that controlled substances inspectors consistently complete pharmacy inspections on the same day initiated and that the Controlled Substances Coordinator monitors compliance.
	The facility complied with any additional elements required by VHA or local policy.		

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it.[d]

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community February 2014 through February 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.		
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.		
	The facility complied with any additional elements required by VHA or local policy.		

Mammography Services

The purpose of this review was to determine whether the facility complied with selected VHA requirements regarding the provision of mammography services for women veterans.[e]

We reviewed relevant documents and the EHRs of 29 women veterans 50–74 years of age who had a screening mammogram during calendar years 2013 and 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy addressing mammography services that included required elements.		
	If the facility outsourced mammograms, it defined requirements for turnaround time.		
X	Clinicians linked mammogram results to the radiology order in the EHR.	• Clinicians had not linked mammogram results to the radiology order in any of the 29 EHRs.	**13.** We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.
	Mammogram result reports included required elements.		
	Interpreting clinicians reported mammogram results using American College of Radiology codes.		
X	The facility sent written summaries of the mammogram results in lay terms to patients within 30 days of the procedure date.	• Four EHRs did not contain documentation that the facility sent lay mammogram results to patients within 30 days of the procedure.	**14.** We recommended that the facility send written lay mammogram results to patients within 30 days of the procedure, that electronic health records reflect this, and that facility managers monitor compliance.
	Clinicians communicated “suspicious” or “highly suggestive of malignancy” results and recommended actions to the patient within 5 business days of the procedure and documented this in the EHR.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Clinicians communicated incomplete or "probably benign" results to the patient within 14 days from availability of the results and documented this in the EHR.	• Two of the three applicable EHRs did not contain documentation that clinicians communicated incomplete or "probably benign" results to the patients within 14 days from availability of the results.	**15.** We recommended that clinicians communicate incomplete or "probably benign" results to patients within 14 days from availability of the results and document this in the electronic health record and that facility managers monitor compliance.
	The facility ensured ordering clinicians received signed written mammography reports within 30 days of the procedure date.		
NA	The facility ensured communication of "suspicious" or "highly suggestive of malignancy" results and the recommended course of action to the ordering clinician or responsible designee within 3 business days of the procedure date.		
	The facility designated a full-time Women Veterans Program Manager who was a health care professional with a minimal allotment of clinical time to maintain clinical competency.		
	The facility had established effective mammography oversight processes.		
	The facility complied with any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[f]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 30 patients assessed to be at high risk for suicide and the training records of 30 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator and a plan for back-up.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.		
X	The facility provided suicide prevention training to new employees and community organizations.	• Twenty-four training records (80 percent) contained no evidence of suicide prevention training.	**16.** We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.		
	The facility had a process to follow up on patients who missed MH appointments.		
X	Patients had documented safety plans that specifically addressed suicidality.	• Nine EHRs (30 percent) did not contain safety plans.	**17.** We recommended that clinicians ensure all patients assessed to be at high risk for suicide have documented safety plans that specifically address suicidality and that facility managers monitor compliance.
	Patients and/or their families participated in safety plan development.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians documented safety plans that contained all required elements.		
X	Clinicians documented that the patients and/or their families received a copy of the safety plan.	• In 10 of the 21 applicable EHRs, clinicians did not document that the patients and/or their families received a copy of the safety plan.	**18.** We recommended that clinicians ensure that patients and/or their families receive a copy of the safety plan and that facility managers monitor compliance.
	Clinicians placed flags in the EHRs for high-risk patients.		
	The facility complied with any additional elements required by VHA or local policy.		

Management of Workplace Violence

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of workplace violence.[g]

We reviewed relevant documents, two Reports of Contact from disruptive patient/employee/other (visitor) incidents that occurred during the 18-month period January 2014–July 2015, and 15 training records of employees who worked in areas at low, moderate, or high risk for violence. Additionally, we conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing workplace violence.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: • An Employee Threat Assessment Team • A Disruptive Behavior Committee/Board • A disruptive behavior reporting and tracking system	• The facility had not implemented an Employee Threat Assessment Team or a centralized disruptive behavior reporting and tracking system.	**19.** We recommended that the facility implement an Employee Threat Assessment Team and a centralized disruptive behavior reporting and tracking system.
	The facility used and tested appropriate physical security precautions and equipment in accordance with the local risk assessment.		
	The facility had an employee security training plan that either used the mandated prevention and management of disruptive behavior training or an alternative that addressed the issues of awareness, preparedness, precautions, and police assistance. • Employees received the required training.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility managed selected incidents appropriately according to its policy.		
	The facility complied with any additional elements required by VHA or local policy.		

MH RRTP

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

We reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program residential unit, and conversed with key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
X	MH RRTP employees conducted and documented monthly MH RRTP self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.	Six months of self-inspection documentation reviewed: • Documentation for five monthly self-inspections did not include safety, security, and privacy.	**20.** We recommended that facility managers ensure that monthly self-inspection documentation includes safety, security, and privacy.
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks, and bathrooms had door locks.		
	Residents secured medications in their rooms.		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity with Previous CAP Recommendations

Follow-Up on QM

As a follow-up to recommendations from our previous CAP review, we reassessed facility compliance with peer review processes and Focused Professional Practice Evaluation initiation for newly hired licensed independent practitioners.[i]

Peer Review. VHA requires the tracking of corrective actions from the protected peer review process and the reporting of completed actions to the Peer Review Committee. The facility did not track corrective action items from May 2014 to April 2015. The facility resumed tracking in May 2015.

Focused Professional Practice Evaluations. VHA requires facilities to initiate a Focused Professional Practice Evaluation for newly hired licensed independent practitioners at the time or before they begin providing patient care. The facility did not initiate Focused Professional Practice Evaluations for two of five newly hired licensed independent practitioners until several months after they began providing care.

Recommendations

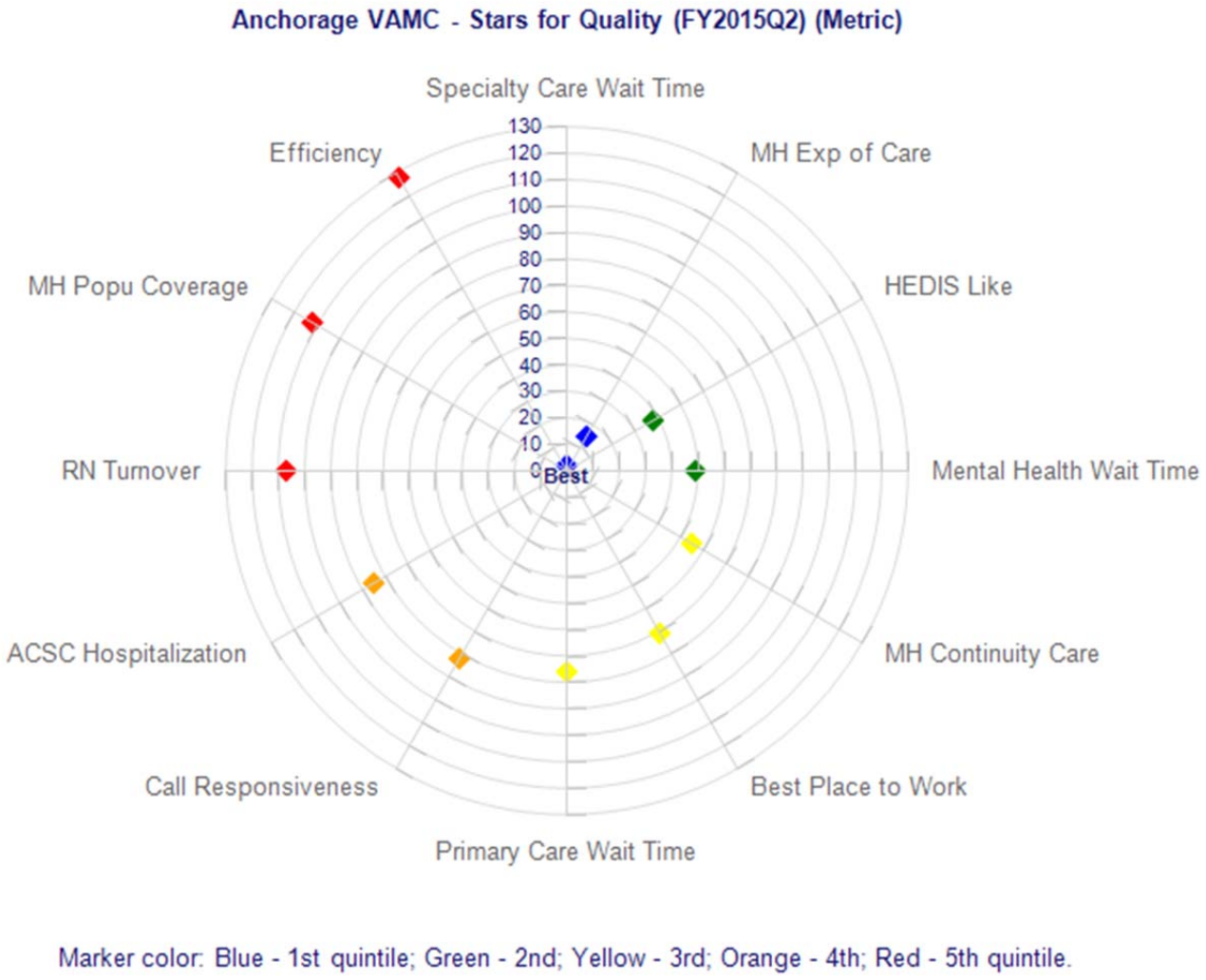
21. We recommended that the facility Risk Manager continue the recently implemented peer review corrective action tracking process and ensure actions are completed and reported to the Peer Review Committee.

22. We recommended that facility managers consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners at the time or before they begin providing patient care.

Facility Profile (Anchorage/463) FY 2015 through July 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$195
Number of:	
• **Unique Patients**	18,997
• **Outpatient Visits**	142,591
• **Unique Employees**[2]	396
Type and Number of Operating Beds:	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	50
Average Daily Census:	
• **Hospital**	NA
• **Community Living Center**	NA
• **MH**	28
Number of Community Based Outpatient Clinics	3
Location(s)/Station Number(s)	Fort Wainwright/463GA Kenai/463GB Wasilla/463GC
Veterans Integrated Service Network Number	20

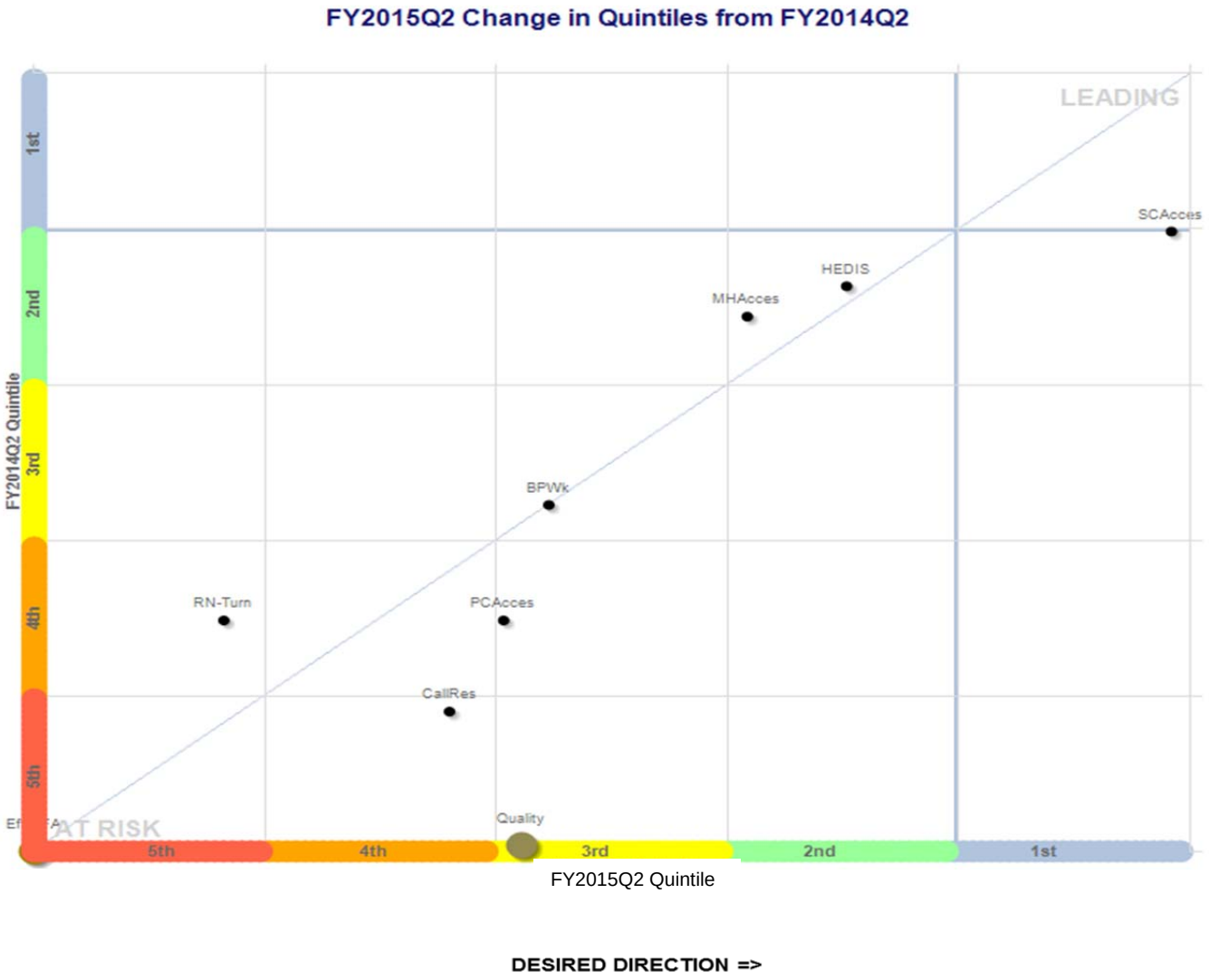
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	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
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	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-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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: September 18, 2015

From: Director, Northwest Network (10N20)

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

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

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

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

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

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

(original signed by:)
Lawrence H. Carroll

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 10, 2015

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

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

To: Director, Northwest Network (10N20)

1. The findings from the CAP Review of the Alaska VA Healthcare System, Anchorage, AK review by the Office of the Inspector General (OIG) conducted August 3, 2015 through August 7, 2015 have been reviewed.

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

(FOR)
Linda L. Boyle, DM, MSN, RN
Interim Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director and other key members required by local policy attend Quality Committee meetings or have a delegate represent them.

Concur

Target date for completion: December 31, 2015

Facility response: If a key member of the Quality Committee is not available to attend a meeting, a delegate empowered to represent the member will attend the meeting and the minutes will reflect the position they are representing. We will monitor until compliance is >90% for three consecutive months.

Recommendation 2. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: December 31, 2015

Facility response: A 100 percent audit of existing Licensed Independent Practitioner folders will be conducted to ensure folders do not contain non-allowed information. We will monitor new LIP folders monthly to ensure compliance is >90% for three consecutive months, and then we will convert to reporting on a quarterly basis to the Medical Executive Board.

Recommendation 3. We recommended that the facility establish a committee to provide oversight of the safe patient handling program.

Concur

Target date for completion: April 30, 2016

Facility response: The Environment of Care Committee will provide oversight of the safe patient handling program. This program will be added to the standing committee agenda for quarterly reporting.

Recommendation 4. We recommended that the facility analyze electronic health record quality data at least quarterly.

Concur

Target date for completion: April 30, 2016

Facility response: The Medical Records Committee will collect EHR data monthly and document quarterly analysis in committee minutes.

Recommendation 5. We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents.

Concur

Target date for completion: January 31, 2016

Facility response: The numbered memorandum covering scanning will be updated to include: the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a complete review of scanned documents to ensure retrievability, and quality assurance reviews on a sample of the scanned documents. We will monitor until compliance is >90% for three consecutive months.

Recommendation 6. We recommended that the Chief of Staff complete an audit of all licensed independent practitioners' privileges to ensure they are current and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: The Chief of Staff in conjunction with the facility managers will complete an audit of all licensed independent practitioners' privileges to ensure they are current and report outcomes to the Medical Executive Board. Facility managers will monitor all licensed independent practitioners' privileges and report any clinical activates for which a licensed independent practitioner is not privileged to the Chief of Staff immediately.

Recommendation 7. We recommended that facility managers ensure the health care occupancy building has at least one fire drill during administrative hours per quarter and monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: The Safety Manager will ensure the health care occupancy building has at least one fire drill during administrative hours per quarter. The fire drills will be documented in the Environment of Care Committee meeting minutes and monitored by the EOC Committee.

Recommendation 8. We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Clean supplies are now separated from infectious materials. The clean and dirty utility rooms are now clearly marked with signage. We will monitor compliance during Environment of Care Rounds.

Recommendation 9. We recommended that the facility revise the tuberculosis prevention plan policy to reflect current status of negative air exchange rooms in the primary care clinic and ensure employees are aware of procedures to care for infectious patients in lieu of negative air exchange rooms.

Concur

Target date for completion: December 31, 2015

Facility response: Facility has identified an alternative processes for managing patients with suspected active pulmonary tuberculosis. We no longer have identified negative pressure rooms. We will update our policy to reflect current practice and educate staff.

Recommendation 10. We recommended that facility managers ensure correction of all deficiencies identified during annual physical security surveys.

Concur

Target date for completion: December 31, 2015

Facility response: Facility managers will ensure correction of all deficiencies identified during annual physical security surveys. Items will be tracked to closure in the EOC Committee meeting minutes.

Recommendation 11. We recommended that controlled substances inspectors consistently complete a physical count of all primary care clinics during the 1st month of each quarter and a physical count of 10 line items for all primary care clinics during the 2nd and 3rd months of each quarter and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: December 31, 2015

Facility response: We have developed two worksheets, the "CSI Checklist" and the "Primary Care Non-Omnicell Inventory" to improve the controlled substance inspection process. A physical count of all primary care clinics during the 1st month of each quarter and a physical count of 10 line items for all primary care clinics during the 2nd and 3rd months of each quarter will be documented in the monthly report by the Controlled Substances Coordinator to the Director.

Recommendation 12. We recommended that controlled substances inspectors consistently complete pharmacy inspections on the same day initiated and that the Controlled Substances Coordinator monitors compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Controlled substances inspectors will consistently complete pharmacy inspections on the same day initiated and the Controlled Substances Coordinator will document the date of the pharmacy inspection in the monthly report to the Director.

Recommendation 13. We recommended that clinicians link mammogram results to the radiology order in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: Mammogram results will be linked to the radiology order in the electronic health record and facility managers will monitor compliance and report through the Quality Committee. We will monitor until compliance is >90% for three consecutive months.

Recommendation 14. We recommended that the facility send written lay mammogram results to patients within 30 days of the procedure, that electronic health records reflect this, and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: The facility will send written lay mammogram results to patients within 30 days of the procedure, the electronic health records will reflect this, and facility managers will monitor compliance and report through the Medical Records Committee. We will monitor until compliance is >90% for three consecutive months, then we will convert to reporting on a quarterly basis.

Recommendation 15. We recommended that clinicians communicate incomplete or "probably benign" results to patients within 14 days from availability of the results and document this in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Clinicians will communicate incomplete or "probably benign" results to patients within 14 days from availability of the results and document this in the electronic health record and facility managers will monitor compliance through the Medical Records Committee. We will monitor until compliance is >90% for three consecutive months, then we will convert to reporting on a quarterly basis.

Recommendation 16. We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: New employee suicide prevention training will be documented in the employee's TMS education record. Facility managers will monitor and report to the Quality Committee. We will monitor until compliance is >90% for three consecutive months, then we will convert to reporting on a quarterly basis.

Recommendation 17. We recommended that clinicians ensure all patients assessed to be at high risk for suicide have documented safety plans that specifically address suicidality and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Clinicians will ensure that all patients assessed to be at high risk for suicide have documented safety plans that specifically address suicidality and that the Behavioral Health Manager monitors compliance and reports to the Medical Records Committee. We will monitor until compliance is >90% for three consecutive months, then we will convert to reporting on a quarterly basis.

Recommendation 18. We recommended that clinicians ensure that patients and/or their families receive a copy of the safety plan and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: Clinicians will ensure that patients and/or their families receive a copy of the safety plan and document patient/family understanding of the education provided. The Behavioral Health Manager will monitor compliance through the Medical Records Committee. We will monitor until compliance is >90% for three consecutive months, then we will convert to reporting on a quarterly basis.

Recommendation 19. We recommended that the facility implement an Employee Threat Assessment Team and a centralized disruptive behavior reporting and tracking system.

Concur

Target date for completion: July 31, 2016

Facility response: The facility will implement an interdisciplinary team whose primary charge is using evidence-based and data-driven practices for addressing the risk of violence posed by employee-generated behavior(s) that are disruptive or that undermine a culture of safety. The committee will utilize a centralized employee disruptive behavior reporting and tracking system.

Recommendation 20. We recommended that facility managers ensure that monthly self-inspection documentation includes safety, security, and privacy.

Concur

Target date for completion: December 31, 2015

Facility response: Behavioral Health Managers will ensure that monthly self-inspection documentation includes an evaluation of safety, security, and privacy in the Residential Rehabilitation Treatment Program (RRTP). The EOC Committee will monitor the monthly self-inspection results and follow all identified issues to closure.

Recommendation 21. We recommended that the facility Risk Manager continue the recently implemented peer review corrective action tracking process and ensure actions are completed and reported to the Peer Review Committee.

Concur

Target date for completion: December 31, 2015

Facility response: The facility Risk Manager will continue the peer review corrective action tracking process and ensure actions are completed and reported to the Peer Review Committee. We will monitor until compliance is >90% for three consecutive months.

Recommendation 22. We recommended that facility managers consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners at the time or before they begin providing patient care.

Concur

Target date for completion: December 31, 2015

Facility response: Facility managers will consistently initiate Focused Professional Practice Evaluations for newly hired licensed independent practitioners at the time of arrival or before they begin providing patient care. Compliance will be monitored through the Medical Executive Board.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Carol Lukasewicz, RN, BSN, Team Leader Craig Byer, MS, R.R.A. Sarah Mainzer, RN, JD Mary Noel Rees, MPA Monika Spinks, RN, BSN Susan Tostenrude, MS Robert Sproull, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Lin Clegg, PhD Marnette Dhooghe, MS Marc Lainhart, BS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Northwest Network (10N20)
Interim Director, Alaska VA Healthcare System (463/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Lisa Murkowski, Daniel Sullivan
U.S. House of Representatives: Don Young

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

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.02, *Inspection of Controlled Substances*, March 31, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VA Handbook 0730/4, *Security and Law Enforcement*, March 29, 2013.

[d] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

[e] References used for this topic included:
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011.

[f] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of The Joint Commission.

[g] References used for this topic were:
- VHA Directive 2009-008 (also listed as 2010-008), *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Under Secretary for Health, "Violent Behavior Prevention Program," Information Letter 10-97-006, February 3, 1997.
- Various requirements of the Occupational Safety and Health Administration.

[h] References used for this topic were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[i] References used for this topic were:
- VHA Directive 2010-025, *Peer Review*, June 3, 2010.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.