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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage

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Figure 1. *Colonel Mary Louise Rasmuson Campus of the Alaska VA Healthcare System in Anchorage.*

Source: https://www.va.gov/alaska-health-care/ (*accessed April 4, 2023*).

Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the outpatient settings of the Alaska VA Healthcare System, which includes the Colonel Mary Louise Rasmuson Campus in Anchorage and other outpatient clinics in Alaska.[1] The inspection covers key clinical and administrative processes that are associated with promoting quality care.

Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years and selects and evaluates specific areas of focus each year. At the time of this inspection, the OIG focused on core processes in the following five areas of clinical and administrative operations:

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

The OIG initiated an unannounced inspection of the Alaska VA Healthcare System during the week of March 20, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of 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 the healthcare system's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued three recommendations to the Director in the Environment of Care and Mental Health areas of review. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

[1] The Alaska VA Healthcare System does not provide inpatient care.

with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 18.

VA Comments

The Veterans Integrated Service Network Director and Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 20-21, 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 conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the outpatient settings of the Alaska VA Healthcare System examines a broad range of key clinical and administrative processes associated with positive patient outcomes.[1] The OIG reports its findings to Veterans Integrated Service Network (VISN) and healthcare system leaders so they can make informed decisions to improve care.[2]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[3] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[4]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[5]

1. Leadership and organizational risks
2. Quality, safety, and value
3. Medical staff privileging
4. Environment of care
5. Mental health (focusing on suicide prevention initiatives)

[1] The Alaska VA Healthcare System does not provide inpatient care.

[2] VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

[3] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[4] Danae F. Sfantou et al., "Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

[5] CHIP site visits addressed these processes during fiscal year (FY) 2023 (October 1, 2022, through September 30, 2023); they may differ from prior years' focus areas.

Methodology

The Alaska VA Healthcare System includes the Colonel Mary Louise Rasmuson Campus in Anchorage and other outpatient clinics in Alaska. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of March 20, 2023.[6] During the site visit, the OIG referred concerns that were beyond the scope of this inspection to the OIG's hotline for further review.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[7] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until healthcare system leaders complete corrective actions. The Executive Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[6] The OIG's last comprehensive healthcare inspection of the Alaska VA Healthcare System occurred in July 2019. The Joint Commission performed ambulatory care, behavioral health care, and home care accreditation reviews in August 2022.

[7] Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–424.

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[8] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[9] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[10]

To assess this healthcare system's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and healthcare system leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The healthcare system had a leadership team consisting of the Executive Director (Director), Chief of Staff, Associate Director for Patient/Nursing Services, and Associate Director. The Chief of Staff and Associate Director for Patient/Nursing Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, all four members of the executive leadership team had been in their roles for over a year. To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director for Patient/Nursing Services, and Associate Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

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

[9] Swensen et al., *High-Impact Leadership: Improve Care, Improve the Health of Populations, and Reduce Costs*.

[10] Allan Frankel et al., *A Framework for Safe, Reliable, and Effective Care,* Institute for Healthcare Improvement White Paper, 2017.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $393,841,323 had decreased by almost 6 percent compared to the previous year's budget of $417,728,875.[11] The Director said the system's community care program is one of the most expensive in the country, accounting for two-thirds of the budget.[12] The Associate Director added that the budget decrease had not affected services or support for veterans.

The Director stated the facility does not have a budget deficit and leaders have been able to continue with hiring actions despite the decreased funding. Leaders discussed initiating several programs to reduce registered nurse turnover and improve employee satisfaction. The Director shared that implementing human resources modernization had negatively affected timely onboarding of new staff, which reduced VA's competitiveness with private sector organizations that were able to hire within weeks.[13] In addition, the Chief of Staff stated systems issues related to hiring and onboarding led to staff disappointment with leaders as positions remained unfilled. Finally, the Director cited challenges with hiring licensed practical nurses due to Alaska's lack of education programs in the field.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[14] 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 medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[15] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

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[11] Veterans Health Administration (VHA) Support Service Center.

[12] "VA provides care to Veterans through community providers when VA cannot provide the care needed." "Community Care," Department of Veterans Affairs, accessed January 25, 2023, https://www.va.gov/communitycare/.

[13] Human resources modernization refers to the implementation of shared human resources services intended to provide "efficient, consistent, accurate, timely, and measurable HR [human resources] services that meet the needs of management, supervisors, employees, and HR staff in a cost effective manner while leveraging current resources." Acting Under Secretary for Health (10) memo, "Consolidation of Classification and Retirement Functions," June 28, 2017.

[14] "AES Survey History, Understanding Workplace Experiences in VA," VHA Support Service Center.

[15] The OIG makes no comment on the adequacy of the VHA average. The VHA average is used for comparison purposes only.

The system's scores for the selected question were higher than VHA's for all three years. The Associate Director attributed success to a workgroup comprised of leaders and staff to address and improve communication challenges within the system. The Director added that leaders conduct quarterly visits at the outpatient clinics and town halls to present information and capture staff issues.

Table 1. All Employee Survey Question: Ability to Disclose a Suspected Violation (FYs 2020 through 2022)

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Alaska VA Healthcare System	3.9	4.0	4.0

Source: VA All Employee Survey (accessed November 15, 2022)

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[16] The OIG reviewed responses to two relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Primary care scores were generally lower than VHA averages, which suggest patients were less satisfied with their primary care experiences at this healthcare system compared to VHA patients nationally. The Director stated the slight downward trend in the system's primary care scores was likely due to turnover and lack of continuity among providers. In addition, the Director cited patients having to repeat their stories with their primary care, mental health, or other providers as a reason for lower satisfaction. To address these concerns, the Director reported implementing veteran experience workgroups to identify root causes of dissatisfaction and make improvements.

Although specialty care scores were higher than VHA's, they indicated patients' satisfaction with their specialty care experiences declined over time. The Director attributed the decline to the limited availability of specialty care services as well as the impact of COVID-19. The

[16] "Patient Experiences Survey Results," VHA Support Service Center.

Director explained that leaders had added chiropractic services at the main facility and planned to expand them to the community-based outpatient clinics to increase patient satisfaction.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?**	82.5	85.1	81.9	79.4	81.7	81.2
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?**	84.8	86.1	83.3	85.0	83.1	84.0

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8, 2022).

**The response average is the percent of "Very satisfied" and "Satisfied" responses.*

Identified Factors Related to Possible Lapses in Care and Healthcare System Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[17] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[18] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[17] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

[18] The Joint Commission, *Standards Manual*, E-dition, July 1, 2022. A culture of safety is "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." "Hospital Survey on Patient Safety Culture: User's Guide," Agency for Healthcare Research and Quality, July 2018, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/userguide/hospcult.pdf.

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[19]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[20] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's 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."[21] Lastly, a large-scale disclosure is "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."[22] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[23]

The OIG requested a list of sentinel events and institutional and large-scale disclosures that occurred during FY 2022 and reviewed the information staff provided. The Patient Safety Manager reported reviewing the patient safety events that staff entered into the Joint Patient Safety Reporting system to identify sentinel events.[24] The Chief, Quality Management stated quality management staff review and discuss the events with executive leaders during daily morning meetings. The Patient Safety Manager stated that quality management leaders then relay sentinel events to the Risk Manager to determine whether an institutional disclosure is indicated.

The OIG noted that leaders did not conduct an institutional disclosure for the facility's only sentinel event that occurred in FY 2022. According to the Risk Manager, the sentinel event did not occur during patient care; therefore, an institutional disclosure was not required.[25] The Risk Manager identified three additional events through a patient complaint, the Joint Patient Safety

[19] Jim Conway et al., *Respectful Management of Serious Clinical Adverse Events (2nd ed.)*, Institute for Healthcare Improvement White Paper, 2011.

[20] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

[21] VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

[22] VHA Directive 1004.08.

[23] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The new directive contains similar language regarding patient safety as the rescinded handbook.)

[24] "The Joint Patient Safety Reporting (JPSR) System is the Veterans Health Administration (VHA) patient safety event reporting system and database." VHA National Center for Patient Safety, *Guidebook for JPSR Business Rules and Guidance*, November 2021.

[25] The sentinel event involved a fall with injury that occurred at the facility but was not a result of direct patient care.

Reporting system, and a provider concern that did not meet The Joint Commission's definition of a sentinel event. However, leaders determined that institutional disclosures were appropriate in these cases and completed the disclosure actions.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[26] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[27] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[28]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[29] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[30]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[31] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[32] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[33]

The OIG team interviewed key managers and staff and evaluated peer reviews and patient safety reports.

Quality, Safety, and Value Findings and Recommendations

The OIG made no recommendations.

[26] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[27] VHA Directive 1100.16, *Health Care Accreditation of VHA Facilities and Programs*, July 19, 2022.

[28] VHA Directive 1100.16.

[29] VHA Handbook 1050.01; VHA Directive 1050.01.

[30] The Joint Commission, *Standards Manual*, E-dition, PI.03.01.01, PI.04.01.01, January 1, 2022.

[31] 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, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[32] VHA Directive 1190.

[33] VHA Directive 1190.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[34] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[35]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[38]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[39] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires each facility to have credentialing and

[34] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[40]

The OIG interviewed key managers and selected and reviewed the privileging folders of 19 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[40] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[41] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[42]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[43]

During the OIG's review of the environment of care, the inspection team examined relevant documents, interviewed managers and staff, and inspected three patient care areas:

- Mat-Su Clinic
- Primary Care and women's health clinic
- Specialty Care Outpatient Clinic

Environment of Care Findings and Recommendations

VHA requires Supply Chain Management, Engineering, or Facility Management Service staff to monitor temperature and humidity in all clean and sterile storage rooms to maintain a stable environment.[44] In one of the three areas inspected, the OIG found commercially packaged sterile supplies stored in an environment without temperature and humidity monitoring.[45] Inappropriate storage could cause items to lose their sterile properties and result in patient harm. The Safety

[41] VHA Directive 1608, *Comprehensive Environment of Care Program*, June 21, 2021. (This directive was in effect at the time of the inspection. VHA amended it September 7, 2023.)

[42] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[43] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

[44] VHA Directive 1761.

[45] The OIG found the deficiency in the Mat-Su Clinic storage room.

and Occupational Health Manager reported staff did not re-install the temperature and humidity tracking device when they relocated the storage room during the clinic's recent remodel.

Recommendation 1

1. The Executive Director ensures Supply Chain Management, Engineering, or Facility Management Service staff monitor temperature and humidity in all clean and sterile storage rooms to maintain a stable environment.

Healthcare system concurred.

Target date for completion: August 30, 2024

Healthcare system response: The Chief of Facilities Management Service ensured that a Temp Trac monitoring system was installed at the Matsu Community Based Outpatient Clinic - Clinic Supply Room, and the system went live on March 23, 2023. The Chief of Facilities Management Service will complete monthly audits of the monitoring of all clean and sterile storage rooms and present data to the Quality and Safety Council, co-chaired by the Medical Center Director, until sustainment is achieved at 90% or better for 6 consecutive months. The numerator will be the number of observations in which temperature and humidity monitoring occurred and the denominator will be the total number of observations in the clean and sterile storage rooms.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[46] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[47] The suicide rate for veterans was higher than for nonveteran adults during 2020.[48] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[49]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[50] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[51]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[52]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 41 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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[46] VA Secretary memo, "Agency-Wide Required Suicide Prevention Training," October 15, 2020.

[47] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 14, 2022.

[48] VA Office of Mental Health and Suicide Prevention, *2022 National Veteran Suicide Prevention Annual Report*, September 2022.

[49] Congressional Research Service, "Veteran Suicide Prevention," IF11886 version 2, July 29, 2021.

[50] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)," November 13, 2020. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," November 23, 2022.)

[51] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Suicide Behavior and Overdose Reporting," July 20, 2021. (This memo was superseded by the Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Update to Suicide Behavior and Overdose Reporting," May 9, 2023.)

[52] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. "Very large CBOCs [community-based outpatient clinics] are those that serve more than 10,000 unique veterans each year." VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. (VHA rescinded and replaced this handbook with VHA Directive 1160.01, *Uniform Mental Health Services in VHA Medical Points of Service*, April 27, 2023.)

Mental Health Findings and Recommendations

VHA requires the Suicide Prevention Coordinator to report suicide-related events monthly to "local mental health leadership and quality management."[53] The OIG found that for five of six months between April 1 and September 30, 2022, the Suicide Prevention Coordinator did not report suicide-related events monthly to quality management staff. The lack of monthly reporting could hinder leaders' oversight and result in missed opportunities for them to identify needed improvements in suicide prevention processes. The Chief, Quality Management acknowledged being unaware of the required reporting frequency and believing that completing an issue brief for each veteran suicide satisfied the requirement for reporting to quality management staff.[54]

Recommendation 2

2. The Executive Director ensures the Suicide Prevention Coordinator reports suicide-related events monthly to quality management staff.

Healthcare system concurred.

Target date for completion: July 26, 2024

Healthcare system response: The Suicide Prevention Coordinator will report suicide-related events monthly to the Quality and Safety Council, co-chaired by the Medical Center Director until sustainment is achieved at 90% or better for 6 consecutive months. The numerator will be the number of meeting minutes that contain a report from the Suicide Prevention Coordinator to the Quality and Safety Council and the denominator will reflect a value of 1 for a month with any suicide-related events reported.

VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive suicide risk screen in ambulatory care settings.[55] The OIG estimated that providers did not complete evaluations on the same day as a positive screen for 42 (95% CI: 27 to 58) percent of patients, which is statistically significantly above the OIG's

[53] VHA Directive 1160.07.

[54] "Issue Briefs are drafted to provide specific information to leadership within the organization, working through the appropriate chain of command, regarding a situation/event/issue. Issue Briefs are designed to provide clear, concise and factual information about unusual incidents, deaths, disasters, or anything else that might generate media interest or impact care." Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, March 29, 2018.

[55] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy);" Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)."

10 percent deficiency benchmark.[56] Failure to promptly evaluate suicide risk could result in missed opportunities for providers to identify patients at imminent risk for suicide and intervene. The Associate Chief of Staff, Primary Care attributed the noncompliance to primary care providers forgetting to use the Comprehensive Suicide Risk Evaluation template while patients were present during appointments, resulting in the late entries.

Recommendation 3

3. The Executive Director ensures providers complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.

Healthcare system concurred.

Target date for completion: October 25, 2024

Healthcare system response: The Suicide Prevention Coordinator will audit all electronic health records containing a positive Columbia-Suicide Severity Risk Screening monthly for completion of a Comprehensive Suicide Risk Evaluation. Measure of compliance will use number of charts with a positive Columbia-Suicide Severity Risk Screen as the denominator and the number of subsequently timely completed Comprehensive Suicide Risk Evaluations as the numerator. A minimum compliance of 90 percent will be achieved for 6 consecutive months. The Suicide Prevention Coordinator will present the monthly audit numerator, denominator, and compliance percentage monthly to the Quality and Safety Council, which is co-chaired by the Medical Center Director.

[56] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided three recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this healthcare system. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines three OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Executive Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• None
Medical Staff Privileging	• None
Environment of Care	• Supply Chain Management, Engineering, or Facility Management Service staff monitor temperature and humidity in all clean and sterile storage rooms to maintain a stable environment.
Mental Health: Suicide Prevention Initiatives	• The Suicide Prevention Coordinator reports suicide-related events monthly to quality management staff. • Providers complete the Comprehensive Suicide Risk Evaluation on the same day as a positive suicide risk screen in ambulatory care settings.

Appendix B: Healthcare System Profile

The table below provides general background information for this low complexity (3) healthcare system reporting to VISN 20.[1]

Table B.1. Profile for Alaska VA Healthcare System (463)
(October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$351,209,570	$417,728,875	$393,841,323
Number of:			
• Unique patients	22,914	23,753	24,249
• Outpatient visits	171,017	187,785	181,792
• Unique employees§	575	558	539
Type and number of operating beds:			
• Domiciliary	50	50	50
• Residential rehabilitation	24	24	24
Average daily census:			
• Domiciliary	25	17	27
• Residential rehabilitation	9	4	8

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

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

**October 1, 2019, through September 30, 2020.*

†*October 1, 2020, through September 30, 2021.*

‡*October 1, 2021, through September 30, 2022.*

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

[1] VHA medical facilities are classified according to a 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." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: January 23, 2024

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

Subj: Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage

To: Director, Office of Healthcare Inspections (54CH01)

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

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage, Alaska.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in the responses.

(Original signed by:)

Teresa D. Boyd, DO

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: January 18, 2024

From: Executive Director, Alaska VA Healthcare System (463)

Subj: Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage

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

1. Thank you for the opportunity to provide a response to the findings from the draft report of the Comprehensive Healthcare Inspection of the Alaska VA Healthcare System in Anchorage.
2. I concur with the findings and recommendations and will ensure that actions to correct these findings are completed as described in responses to the draft report.

(Original signed by:)

Thomas Steinbrunner, FACHE
Executive Director

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